Medical Economics

EMBER 1939

Medical Economics

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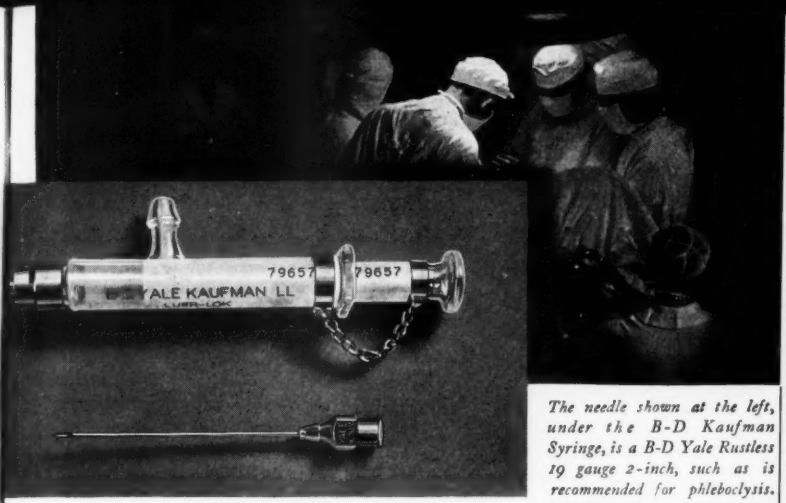

The needle shown at the left, under the B-D Kaufman Syringe, is a B-D Yale Rustless 19 gauge 2-inch, such as is recommended for phleboclysis.

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THE B-D Kaufman Syringe—made either with a regular Luer slip tip, or with the B-D Luer-Lok tip as illustrated—has found a remarkably wide field of usefulness. Used with a B-D 300 cc. gravity tube, a glass observation tube, and B-D rubber tubing (Outfit No. K606/0, price $6.50), it is standard equipment with many surgeons for following operations:

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B-D PRODUCTS *Made for the Profession*

1939

XUM

WANTED

TO THE EDITORS: No other land has finer medical skill than ours. In no other is more skill available.

But how is the public to know it?

Nothing in school, business, home, church, or club explains why cure of sickness depends on intelligent medical care. Our public is weltering among spine-punching, foot-twisting, food fads, culture clubs, dieting, spring tonics, fasting, thought control, mud baths, vibration, hiking, rolling, reducing, revivals, spiritualism, vegetarianism, and nudism.

Our greatest need is medical education of the public. It is the doctor's responsibility to provide it.

MEDICAL ECONOMICS now supplies us with an excellent folder on socialized medicine. It may be a model for missionary work. Many more such folders should be distributed to our patients—each with its message.

We should tell them, for example:

Why medical science offers the only hope for the tuberculous, diabetic, cardiac, cancerous, syphilitic, and insane.

How epidemics that decimated continents are now eradicated.

How communicable infections are controlled.

How horrible diseases of foreign lands are excluded from the United States.

Why babies have more than a fifty-fifty chance of living today.

How human welfare, nutrition, longevity, sanitation, and conquest of disease can be promoted by medical science.

It must be emphasized that *there is no other way.*

Belle S. Mooney, M.D.
Chicago, Ill.

[*In addition to the "Family Doctor or Federal Agent?" folder which Dr. Mooney mentions,* MEDICAL ECONOMICS *is now distributing stamps. These stamps, affixed to outgoing mail, warn the public to keep politics out of medicine. For details, see page 22, this issue.*—THE EDITORS]

SWISS

TO THE EDITORS: With reference to Dr. Hargett's letter in June MEDICAL ECONOMICS:

Postgraduate courses in English are now offered by five Swiss medical schools. All arrangements are complete to meet the demands of American physicians desiring to study abroad.

"Ars Medici," of which I am associate editor, has been appearing without interruption in Basle, Switzerland, since the *Anschluss.* Further information as to study abroad may be obtained by addressing me at 2013 Bryant Ave., New York City.

J. E. Rosenfeld, M.D.
New York City

TO THE EDITORS: When Dr. Hargett extols a non-existent Swiss "school" and condemns tried, useful Vienna, I must protest. Having spent six months in Vienna last year, and having talked to men who have lately returned, I feel qualified to speak.

Why go to Vienna?

These were my reasons:

Location—Living in one of the best medical centers, I found it impossible to attend postgraduate courses regularly because of pressure of practice. I could not stay home, attend lectures, and still have time to study.

Quality of instruction—Viennese professors are chosen because of ability to instruct. Even undergradu-

ates may drop an unpopular instructor. A man who fails to hand out "meat" soon has no class. Our schools have not learned that ability to *do* does not connote ability to *tell how*.

Material—Partly because of the ignorance of the laity, the *Allgemeines Krankenhaus* contains more advanced cases, complications, stages, and unusual conditions than any other teaching institution. Autopsies are performed on *all* bodies. The opportunity for study of pathology and follow-up is unparalleled.

Cadaver surgery—Of utmost importance is this chance for harmless surgery and study of practical anatomy. Only $4 each, even at hospitals, bodies may be bought still more cheaply from the *Dieners* ($1.25, *sub rosa*). Any surgery is permitted except that which will disfigure the face. The confidence to be derived from a mastoidectomy, for example, followed by dissection of the facial nerve, is not easily duplicated.

The people—The opportunity to live among friendly, well-mannered, hospitable, good-natured folk is no small factor. Having gone there ready to answer "go to hell" to "Heil Hitler," I was converted to respect and affection for these pleasant people—especially when one comprehends their twenty-five years of travail. Don't tell me these people persecute anyone! We heard, hunted, found no instance. I do not deny the possibility, but failed to see any actual examples. Those from concentration camps looked better fed and rested than we did. Since my forbears are French, my prejudice before my trip was quite the other way.

Dr. Hargett says the A.M.A. of Vienna Blue Book is half its former size. He fails to mention how padded its predecessor was. At least, the present issue is truthful...

To anyone who contemplates going abroad, consideration of the above may be of value. I learned what I went for—and more: Tolerance for a maligned and misunderstood people whom I had detested from blind prejudice; respect for American colleagues who, accused of going to Vienna for a "binge," worked from six in the morning to ten at night six or seven days a week; respect for physicians of all nations who, lacking understanding and cooperation, coerced and red-tape bound, still do a better job than any other profession.

I'd go to Vienna again.

Darius Gray Ornstor, M.D.
Philadelphia, Pa.

DISCHARGE

TO THE EDITORS: What seems to me a peculiar situation exists at the hospital with which I have been connected for eleven years. Every staff member must sign an undated resignation. This enables the hospital superiors to discharge any physician by the mere addition of a date and without further procedure or explanation.

M.D., Brooklyn, N.Y.

REVERSAL?

TO THE EDITORS: In your July "Speaking Frankly" department, Dr. Nat Kanner angrily assailed MEDICAL ECONOMICS for mentioning the "unethical practices" of some refugee physicians. He called such charges "nonsense."

Yet I notice that the same Dr. Kanner, writing in a publication called The I.P.A. Voice, has this to say on the subject:

"The medical refugee has started to practice here. Some are unfamiliar with the American Code of Ethics. They do not know that undercutting fees, solicitation of patients, advertising, discrediting the American doctor by calling themselves "German professors," saying that the American doctor is inferior to the German doctor, is unethical and morally wrong. It is the American Code of Ethics, of fair competition, that they

1916

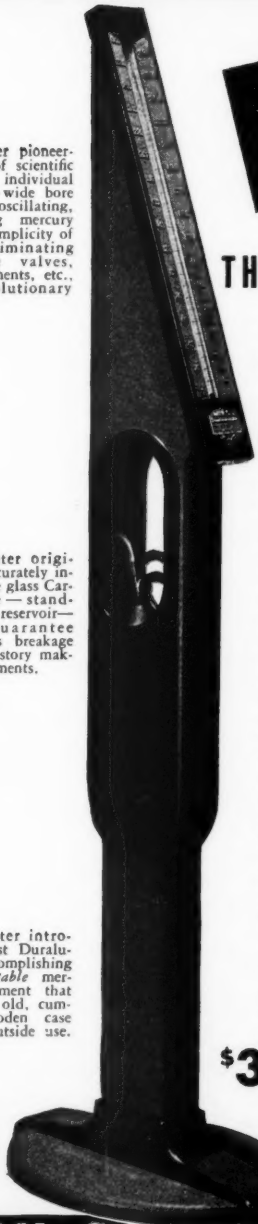
Baumanometer pioneered method of scientific accuracy by individual calibration — wide bore tube — non-oscillating, non-spilling mercury column — simplicity of design, eliminating troublesome valves, scale adjustments, etc., — all revolutionary features.

1926

Baumanometer originated the accurately interchangeable glass Cartridge Tube — standardized steel reservoir— Lifetime Guarantee against glass breakage and other history making improvements.

1932

Baumanometer introduced die-cast Duralumin case, accomplishing a *truly portable* mercurial instrument that replaced the old, cumbersome wooden case model for outside use.



1939

THE STANDBY MODEL

We again originate—the STANDBY Model Lifetime Baumanometer, a truly major piece of equipment—in step with the present day advanced importance of bloodpressure. This revolutionary new Lifetime Baumanometer is destined to make history anew. Designed primarily for office work, it stands on the floor and is highly practical for hospital bedside use and ideal for the operating room.

The EXACTILT scale of the STANDBY, utilized here for the first time in any mercury-gravity bloodpressure instrument is permanently fixed at the exact angle for maximum reading efficiency from either the sitting or standing position—no adjustments necessary. The angle of the EXACTILT scale is compensated for by individual calibration.

The STANDBY Model is beautifully designed in die-cast Dow metal (Magnesium), the lightest metal used industrially—one-third lighter than aluminum. It weighs 6½ pounds and is 38¼ inches high. The compartment that holds the inflation system is an integral part of the instument. The rubber parts, bulb, bag and tubing are all made of genuine Latex. The recessed glass Cartridge Tube is guaranteed against breakage for the doctor's lifetime.

$39.50 *Your surgical instrument dealer will gladly sho you this new instrume...*

Lifetime Baumanometer
STANDARD FOR BLOODPRESSURE

A RAUM CO. INC. NEW YORK

must learn at once, and learn it hard."

What is responsible for this sudden change of tune? Could it be that a foreigner, perchance, has poached on *his* preserves?

M.D., New Jersey

SUCCESS

TO THE EDITORS: Thank you for publishing "To What Do You Attribute Your Success?" in the August issue. It is the most valuable article for physicians I have ever read.

M.D., Illinois

TO THE EDITORS: I agree with most of the advice in your article on the elements of success. But I do not think it advisable to be a "joiner." If a doctor mingles too much socially with his patients, familiarity may well breed contempt. He will not be held in as high esteem professionally as he might otherwise.

Maurice Stayer, M.D.
Johnstown, Pa.

TO THE EDITORS: The philosophy in your article on success should find commendation and approval from family doctors the country over. The physician gives an excellent formula for continued material benefit as well as for a full, useful, and happy life. Let this story be read and remembered by every medical student in order that he may be helped along the pleasant road to being a real G.P.

J. E. Reeves, M.D.
San Diego, Calif.

HONEYMOONERS

TO THE EDITORS: A laurel to MEDICAL ECONOMICS for daring—in its article "The Crisis in Group Hospitalization"—to discuss frankly a topic of importance hitherto hushed up.

It invokes this moral:

No hospital insurance program—and this goes for health insurance, too—can succeed without the full cooperation of the medical profession. Our role must be more than advisory.

Up to now, the New York group has not recognized this. They have more or less thumbed their noses at organized medicine.

But they are learning the hard way that hospitals are only interested in getting paid for their patients; that patients are only interested in getting hospitalization. In bringing these two together, the problems raised—patient's intent, diagnosis, pre-existing conditions, etc.—are strictly *medical*. They call for direction by medical men.

The hospitalization people better wake up and make the necessary adjustments if they wish their child a happy life. The honeymoon is over.

M.D., New Jersey

SOB

TO THE EDITORS: The average physician's assistant who reads MEDICAL ECONOMICS does not need articles like "Letters to a Doctor's Secretary" so much as she needs "Letters to Patients and Doctors."

The average secretary is overworked and underpaid. She must be nurse, stenographer, x-ray technician, file clerk, social secretary, errand girl, wife's shopper, purchasing agent, nursemaid, bookkeeper, cleaning woman, and general factotum, all in one.

In addition, she is expected to be

charming to discourteous patients.

The personal services these patients require range from getting them a glass of water to supplying them with matches. Those with appointments query innocently: "Is the doctor in?" Those without them expect to be admitted instantly. The business man commands: "Get me Austin 0000 right away." No "please," no "thank you"—and no offer to pay for the call.

Not infrequently, the doctor's wife breaks the monotony of waiting by neighborly calls that cover the town's entire social life. Meanwhile, the secretary must, of course, refrain politely from her necessary typing.

Nor, in general, are doctors model employers. Many are unwilling to spend money on what *they* consider non-essentials. Some are completely lacking in altruism. When a manual on *their* responsibility toward their secretaries is published, perhaps the lady in the outer office will be able to accomplish her daily chores more efficiently.

Ann Onymous

KIDDING

TO THE EDITORS: Your June editorial on the relationship between family physician and specialist was excellent. It expresses my viewpoint (that of the specialist) exactly—*if* the G.P. would play fair.

Patients should consult the family doctor first. But when he treats conditions of which he is ignorant, the patient is not to blame for seeking advice elsewhere.

For instance, I have seen glaucoma treated with zinc, boric acid, and whatnot until sight had been permanently lost. *Then* the case was referred. I have seen glaucoma diagnosed as cataract, and the patient told to wait until blindness ensued, when the "cataract" would be "ripe" for removal.

If the family physician would not attempt to treat *everything* that presents itself, there would be no difficulty. Patients soon discover where the fault lies. The G.P. is kidding himself when he thinks otherwise.

The idea in your editorial can be followed only when the family doctor ceases to be a jack-of-all trades.

M.D., Pennsylvania

BUDGETS

TO THE EDITORS: The average American family is accustomed to budgeting the household. There are budgets for food, furniture, and clothing; budgets for parties, entertainment, and the automobile.

With all this budgeting, the most important necessity is consistently overlooked. I refer, of course, to medical care. Questioning of a number of confirmed budgeteers reveals that frequently this item is not even considered.

Why?

Theodore H. Maday, M.D.
Chicago, Ill.

URBANITE

TO THE EDITORS: A number of years ago, I went to the country to practice. I went in search of experience. Instead, I was disheartened by the antipathy to such accepted protections as vaccination and diphtheria antitoxin. I found ignorance widespread. Rural people fail to accept

medical progress because they are not well educated.

One case I will never forget started out as normal diphtheria. It developed into laryngeal diphtheria that ended fatally because the patient's parents refused to allow the administration of antitoxin and the performance of a tracheotomy. Their attitude was: "Let God take care of it."

No wonder I like my present practice in the city. Facilities are more available; there is opportunity for clinic work; specialists are near at hand; and boards of health are more efficient. In the country, many cases of contagious diseases are not even properly isolated.

M.D., Missouri

"AFFECTIONATE"

TO THE EDITORS: Many articles have been written relative to the general public's high regard for the physician. The truth concerning this great affection, however, may be overrated.

I cite a speech I heard delivered a few years ago by Dr. G. Frank Lydsdon of Chicago. In passing, it may be stated that Dr. Lydsdon was an iconoclast, quick-witted, had a vitriolic tongue, feared no man, and showed an utter disregard for public sentiment. Here is what he had to say:

"The general public holds the doctor in good-natured contempt, as far as his business ability is concerned. He is regarded as a come-on. When the business world looks for easy marks upon whom to unload worthless stocks, bonds, or other holdings, the first ones selected are physicians. The shady banker, when approached by the crooked promoter and offered a bonus for helping gyp the unsuspecting public, is always advised to obtain a complete list of the local physicians, and to sell them first. There are two reasons why the thieving banker offers such advice. First, he knows the average doctor may be taken in by the smooth-tongued promoter; and second, he will probably advise his patients and friends to invest in the stock.

"To understand what kind of a business man the physician is, we have only to consider what the average one does when asked by the patient what his bill is. If he tells him at all, he does so in an apologetic manner. Actually, in most instances, the patient is told the secretary will render a bill.

"How about the banker, or business man when he's telling the physician what *he* owes? Does he adopt this servile or apologetic attitude? No! He has no hesitancy in stating the amount, or in telling the doctor his debt must be paid at once. This is the difference between the physician and the business man."

John E. Hall, M.D.
Miami, Fla.

[*Despite its status as the business magazine of the medical profession,* MEDICAL ECONOMICS *has always emphasized—and wishes to re-emphasize here—the vast difference there is, and should be, between the physician and the business man. Apparently, Dr. Lydsdon overlooked the possibility of combining business knowledge and acumen with medicine's traditional spirit of service and humanitarianism. His somewhat Shavian philosophy led him, instead, to adopt the extremist viewpoint.*—THE EDITORS]

SEAWORTHY

TO THE EDITORS: Ever hear of a committee running a ship? Hardly.

Yet a ship's officers are quite like a committee of specialists. The chief engineer knows more about machinery than the captain. The radio operator is miles ahead of his master on problems of the air waves.

But a ship has only one boss. He is the captain. He listens to the advice of his specialists. He coordinates their reports. But he does not let them run his ship.

A sick patient is like a storm-tossed ship. He can not be guided safely by a group of consultants.

As you say in your June editorial, the family doctor must stand on the bridge. He must provide the consultant with information about the patient. Conversely, he must interpret the specialist's findings. He is the captain of the good ship *Homo Sapiens*.

Specialists who refer first-hand patients to other specialists may be steering them onto the rocks. Few specialists understand the patient as a whole.

Let general practitioners realize this. Let us recognize our duty. We should, of course, consult the specialists. But let us remember that it is our job to weave their fragments into an adequate solution. This requires sufficient skill to make any general practitioner proud of his calling.

M.D., New Jersey

CHARITY

TO THE EDITORS: Many a doctor has seen patients, once in easy circumstances, become pauperized. They are unable to pay their doctors' bills, although many have paid regularly and willingly in the past.

Surely, patients in this situation should not be turned away to clinics.

As an example, a mother brought her child in with an operative mastoid condition. The father had once paid me $500 for a similar operation. Now they were broke.

What could I do? I was willing to perform the operation for nothing. But I couldn't afford to pay hospital expenses of between $75 and $100.

The thought occurred: "Why not start a charity fund?"

I spoke to some of my wealthier patients:

"If I could create a revolving fund of about $200, I'd be able to take care of these people. I would pay the hospital bill. They would receive a receipt in full. If they were ever able to repay the loan—a dollar or two at a time—I'm sure they'd do it, knowing it would help some other worthy person."

It wasn't long before I had the money I needed. What it has meant to me and my patients is beyond anything I ever dreamed.

Many doctors feel they have done their part when they do an operation for nothing. But that's only half the story. Self-respecting people suffer emotionally, if not otherwise, in a charity hospital.

Of course, promiscuous charity is not a good thing. But these old patients of mine *do* get back on their feet, and they *have* shown their appreciation in a substantial way.

Harold Hays, M.D.
New York City

Dramatic RESPONSE IN PRURITUS

Few indeed are the conditions in which symptomatic relief is so welcome, and produces such dramatic response as in pruritus. Control the itching, and the distracted, tormented patient on the verge of hysteria, becomes calm, possessed, comfortable, and cooperative.

Calmitol solves the difficulty of antipruritic medication. Its composition (chlor-iodo-camphoric aldehyde, menthol, and laevohyoscine oleinate in a vehicle of alcohol, ether, and chloroform) insures prompt, dependable, and sustained therapeutic action. Adequate local anesthesia blocks the cutaneous end organs and nerve fibers, preventing the further transmission of offending impulses. Mild antiseptic action and induced active hyperemia contribute to the eradication of infection and hasten the disposal of irritating toxins.

Calmitol may be used to outstanding advantage in all conditions attended by pruritus, regardless of etiology. It is dependably effective in dermatitis venenata including ivy and oak poisoning, dermatitis medicamentosa, ringworm, eczema, urticaria, intertrigo, and pruritus ani, vulvae, and senilis. Generous test quantity sent to physicians on request.

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CALMITOL LIQUID and OINTMENT

THE DEPENDABLE ANTI-PRURITIC

SIDELIGHTS

SEPT. 1939

"The people do not know what is best for them!" said an A.M.A. Trustee at a Congressional hearing this year.

Louis XVI once expressed similar views. They paved *his* path to the guillotine.

Marie Antoinette followed suit. That she was a woman, and a lovely one, didn't save her.

History is full of such examples. In crises, the people assert their power, sometimes in highly dramatic fashion. Usually, it is directed against those who underestimate it—or fail to cultivate it.

The prospect of state medicine in the United States has created just such a crisis. Like the others, it, too, will ultimately be settled by the people.

Starry-eyed social uplifters know this. So do political wire-pullers. Hence the flood of socialistic propaganda assailing the eyes and ears of the public in newspapers, magazines, and on the radio.

Unfortunately, the average citizen has small opportunity to learn the physician's viewpoint. It's true that medical journals publish many excellent articles exposing state medicine. But they are sent only to the profession. Few laymen read them.

That is why MEDICAL ECONOMICS began, back in 1937, to issue its now widely-read pamphlet, "Family Doctor or Federal Agent?" The response continues to prove the need for such educational literature. So far, over half a million copies have been distributed among the public by physicians, medical societies, and other groups.

But no matter how potent, one pamphlet cannot do everything. Additional media must be used to warn the public against a menace which threatens both its pocketbook and its health.

Such a medium is the stamp described on page 22 of this issue.

Stamps, or seals, have proved conclusively their ability to influence public opinion. What's more, they are inexpensive enough to have a broad potential distribution.

Every physician and every medical society with an eye to the future stresses the need for some means of educating the laity in the dangers of state medicine. These stamps are a means which all can use—with propriety, at low cost, and with the likelihood of obtaining *results*.

The time is ripe, politically, to launch this stamp drive now. From today forward, every piece of mail which leaves your office bearing a U.S. stamp on one side and a medical stamp on the other will help seal the door against socialized medicine.

After the World War, the irredentists had their innings. Each nation felt that fragments of its people had been too long under foreign jurisdiction. And most of these irredentists successfully reclaimed lost territory.

Medicine, too, has its "unredeemed" territories which have been invaded by lay workers. With a little effort on the part of the profession these, likewise, could be reclaimed.

Take exercise, for instance. The doctor is—or ought to be—the acknowledged adviser on such a subject. Yet we have let it pass into the hands of laymen.

So too with dieting. Everyone's an

authority on it. And on rest and sleep: What's the best sleeping posture? Should one sleep on the side, back, or stomach? Should the bed be near a window or away from it?

Little points, perhaps—but prob-

lems which patients ought naturally take up with their doctors. That they don't is largely our own fault. We have simply failed to show an interest in these trivia in the design for living, so that they have naturally slid into other spheres of influence.

To reclaim these lost areas, the M.D. must first familiarize himself with the subject. That takes a little time. He must let his patients know that he is prepared to offer a family health service that is complete and practical. That takes a little effort.

But these things are worth the time and effort—on two counts: First because of the immediate returns. Second because they more firmly establish the medical profession as the one accurate source of *all* health knowledge.

At first, we thought it might be an hallucination. But there it was, in black and white: President Roosevelt had vetoed a bill extending Federal medical care to officers of the U.S. Foreign Service.

And his reasons?

The President did not think it proper to furnish Government medical service to such large classes of civilians (in this case, 1,600 employees and their dependents). Furthermore, he thought the cost (in this instance, $21,000 a year) excessive.

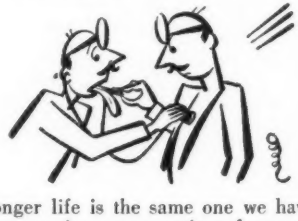
Maybe we have Mr. Roosevelt all wrong. Here we've been representing him as anxious to extend Government medical care to still larger classes of civilians: in fact, to about 120,000,000 of them. And suggesting, further, that he might even approve of spending "insignificant" sums like $2,600,000,000 a year to do it.

We're now ready to take it all back—if the President will only apply his Foreign Service principles to such legislation as the Wagner Health Act.

Dr. S. J. Wolfermann of Fort Smith surprised some of his Arkansas colleagues not long ago by advising them to see a doctor. In fact, he went further. He hinted that it is the duty of the county societies to see that members receive annual check-ups.

Dr. Wolfermann was perfectly serious in his suggestion. So are we when we say that to us it appears highly sound. Almost any necrology list will bear out Dr. Wolfermann's contention that "medical men die early; too many, very suddenly."

After all, his prescription for a



longer life is the same one we have been urging on our patients for years. In this case, it won't hurt us to take some of our own medicine.

The National Grange is concerned over the shortage of country doctors. So, too, are many physicians. But no one with regard for professional standards could assent to the remedy

proposed by the Grange.

It would eliminate all college pre-medical training.

That the Grange could seriously offer such a suggestion indicates its naïveté in medical matters. To Grange officials the doctor is apparently no more than a glorified hired man; the treatment of disease, another chore.

If a high school graduate can go directly to agricultural school and learn how to strip a cow, they reason,

why can't he acquire medical knowledge in the same way? Why must he waste his time on college biology and chemistry?

Every physician knows the answer. But it is clear that the Grange does not. It might be brought home by asking Grange members to go back to primitive cultivation of the soil; to abandon the advances that have made agriculture a science.

If a plow were all that is needed for modern farming, more people might turn to it for a living. But, without further training and equipment, how successful would they be?

The answers apply also to medicine.

Lowering educational standards won't solve any medical problem. On the contrary, it will create others, with serious consequences. If the farmers were treated by high-school graduates, they would be the first to realize the folly of their proposal.

There is, however, a silver lining to the Grange's demand. It indicates the need for physicians in some rural areas. For if they are now willing to accept poorly-trained doctors, how much more grateful these communities would be for practitioners who were prepared to offer them the best of care!

This is something location-hunters may well ponder.

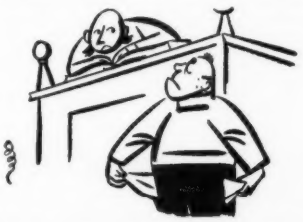
Recently, a man killed his neighbor over a triviality. Brought into court, the confessed murderer was shown to be indigent. Whereupon he was provided with two lawyers for his defense.

After the trial was over and the prisoner had been sentenced to twenty years, each lawyer received a fee of $400, plus $75 for expenses. This, we understand, was paid by the county.

Now we take a man in similar economic circumstances but entirely lacking in criminal characteristics. He's a decent, self-respecting citizen whose only offense is indigency. He becomes sick. He needs an operation costing that same $400.

Does the county pay some private practitioner for the required treatment? You know the answer only too well.

For the life of us, we can't see the difference between these two instances. We can't see why the lawyer should be paid when, in most cases, the doctor is not. Certainly, saving the life of a useful member of so-



ciety is as valuable to the county as rescuing an admitted criminal from the electric chair.

Or were we born twenty years too soon?

STAMP politics out of medicine!

Hardly a doctor in America is unaware of the dangers of political encroachment upon medicine.

But how about the Nation's patients?

They are the power who will ultimately decide whether Government in Medicine is to be or not to be.

Unfortunately, for much of the information it now receives, the public depends upon what is handed to it in the newspapers and over the radio. And that, so far, has consisted largely of propaganda aimed at destroying faith in the family doctor.

Yet it is not too late to rebut that propaganda. A recent survey indicates that only about one in every twenty people has made up his mind on this important question. Private practice still has time to win the support of the other nineteen.

With this article, MEDICAL ECONOMICS presents a simple, quick-acting, and inexpensive medium for reaching every one of the 130,000,000 people in this country, namely: *stamps.*

Intelligently conceived stamps have long demonstrated their effectiveness in molding public opinion. The Christmas Seals of the National Tuberculosis Association are but one example of many that might be mentioned.

Originator of the idea of putting stamps to work for the profession is Dr. Louis R. Effler, former director of education of the Toledo Academy of Medicine. MEDICAL ECONOMICS experimented with Dr. Effler's idea, prepared the copy and design illustrated on this page, and is now distributing these stamps to the profession.

The actual stamp is printed in black and yellow, and is therefore considerably more attractive than the illustration here. It's about three times the size of an ordinary postage stamp. Instead of a long-winded sermon that few people will read, each stamp carries a *brief* message that everyone will read.

Stamps used on envelope flaps are likely to be seen by many people besides the recipient.

STAMPS—An inexpensive means of warning the public against Federalized medicine

The stamps may be affixed to all outgoing mail such as letters and packages. They may also be attached directly to billheads and letterheads. An especially good way to bring them to the attention of the public is to affix them to the backs of envelopes in which bills are mailed each month. A great many people besides the recipients will then see them while they are in transit.

The stamps are easy to use. They are supplied in perforated sheets. They're acceptable to the post office. And the propriety of using them is, of course, self-evident.

To make possible the distribution of the stamps, MEDICAL ECONOMICS has contributed its facilities entirely without profit. The stamps are sold at cost: 20 cents per 100. The coupon below is for your convenience when ordering.

MEDICAL ECONOMICS, INC., RUTHERFORD, NEW JERSEY

Send me ..... stamps at once.

I enclose ..... (@ 20 cents per 100).

Name _____

Address _____

_____

_____

Blueprint for a home-office

Efficiency, beauty, comfort, elasticity—rare indeed is the home-office that combines these four ideals. All the more reason, then, to sit in on a word-tour of the two-story building completed recently for Dr. Stephen Sewell of Spring Lake, N.J.

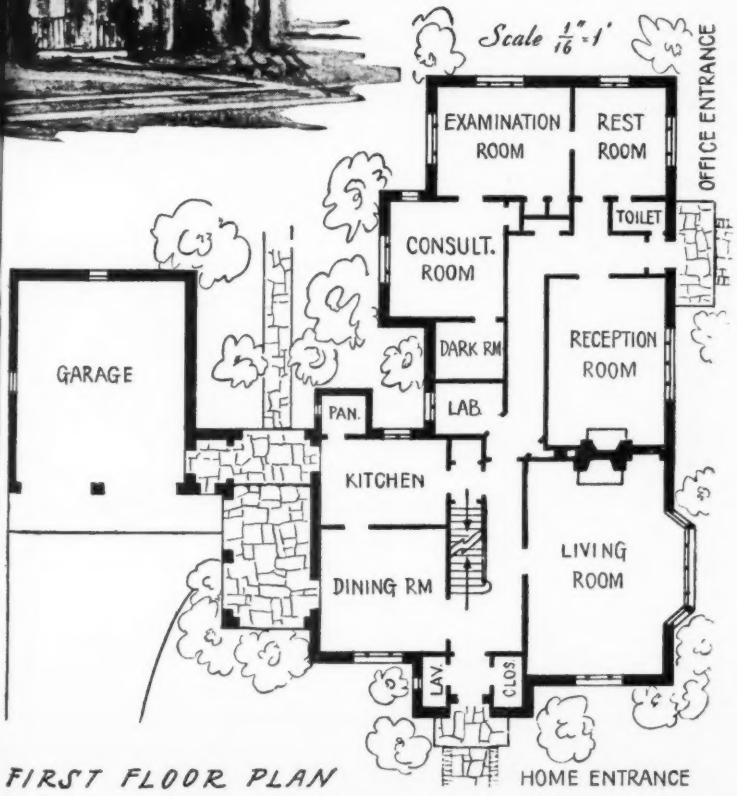
To the eye, its exterior immediately conveys one distinctive quality. That is, dignity. No commercial aura settles over the visiting patient. Nor over the physician's private life. The English-type architecture, the brick and stone trimmings, the slate roof and the half-timber work are responsible for this.

The corner location has been used to full advantage. Entrances to office and residence are entirely separate—almost remote. The residence faces onto a busy thoroughfare; the office, onto a side street where there is ample space for parking.

Dr. Sewell's office connects directly with his home by means of a continuous hallway between the two entrances. Yet doctor and patient may move from dark room to consultation room to examining room to rest room and toilet—all without re-entering this same passageway.

The Colonial-style waiting room has knotty-pine walls and a beam ceiling; a large casement window;

The good taste exemplified by this English-type home-office makes it particularly appropriate for a physician. [John C. Dodd, architect]



FIRST FLOOR PLAN

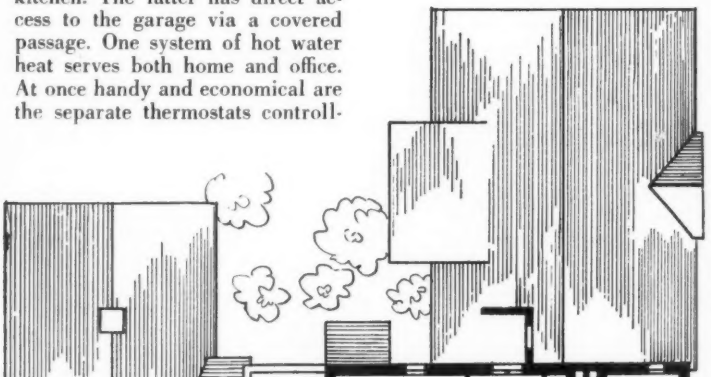
a fireplace—and comfort. Walls and ceilings are tinted by means of color pigments mixed with the plaster. All floors are linoleum over wood.

The examining room—workshop of the office—has a small lavatory, built-in instrument cabinets, and clothes closet. Its walls are tiled to a height of four feet; above that they are painted a dull-finish white. Soundproof doors connect it with the rest room and consultation room. All walls are soundproofed, too.

The doctor's residence has been quite as carefully planned. The main floor comprises a living room, dining room, pantry, hall, and kitchen. The latter has direct access to the garage via a covered passage. One system of hot water heat serves both home and office. At once handy and economical are the separate thermostats controlling each wing. Roofs and all outside walls are insulated with 4" rock wool batts.

The second floor—now consisting of three master bedrooms and two baths—has been planned to accommodate two additional future bedrooms and a bath (over the office quarters). The third floor will allow for still another room and bath.

To all this, add attractive landscaping. And the fact that the center of the town, a bus line, and the railroad are near at hand. It then becomes apparent why this home-office is worth the $20,000 it cost to build.—PATRICK O'SHEEL



SECOND FLOOR PLAN

Health insurance hurdles

The public wants insurance to pay its doctors' bills. The profession is cooperating to supply it. Meanwhile, the problems created are legion. Here are the major ones with which you should have at least a passing acquaintance.

In the race to establish voluntary medical insurance plans, shrewd entrants are looking ahead to the hurdles.

But not all are shrewd. Too many appear to be getting off to a faulty start.

Already such plans to pay for physicians' services—labeled variously as medical expense insurance, medical indemnity protection, and medical prepayment schemes—may be numbered in the hundreds. Some have been in operation for quite awhile. Some are about to start. Others—the great majority—are still being groomed but will be turned loose soon.

Meanwhile, about those hurdles:

At least five must be jumped. They include (1) the problem of obtaining permissive legislation; (2) determining the proper scope of each enterprise; (3) devising a satisfactory system of control; (4) deciding on the benefits and exclusions; and (5) computing premiums, fees, and costs on an actuarially sound basis.

Each of these hurdles is a many-sided problem in itself. Take, for instance, the job of securing permissive legislation. Those who seek it must establish harmonious relations with the State banking department or with the State insurance commission. For one or both of these branches of the State government will subsequently be called upon to approve or disapprove every proposed health insurance association in the light of its conformity with State law.

The scope of the plan must be considered no less carefully. What is the potential market for the service? How will it be made available? Should subscribers be accepted only within certain income limits; or should the system be open to all?

Most authorities agree that a broad base is essential to the success of any prepayment plan. But how to attain it? One means suggested is to encourage employer contributions toward the insurance of low-wage workers.

A number of insurance officials have stated that, in their opinion, far greater difficulty will be experienced selling medical (physician-

service) insurance than selling hospital-service insurance. Some declare, in fact, that even group hospitalization projects will begin to encounter considerably more sales resistance in the near future.

By what means will the plan be controlled? This is one of the highest hurdles of the lot. Should the reins be held by hospital associations? By medical associations? By the laity? Or by some combination of the three?

A small segment of the profession believes, apparently, that control by hospital associations would be advisable since the associations already have the needed machinery set up and in operation. Utilization of this machinery, they say, would reduce organization difficulties and minimize subsequent administrative costs. The great majority of the profession, however, seems convinced of the fact that control by hospital associations would foreshadow the ultimate domination of the private practitioner.

Another faction holds that medical men have neither the time nor the inclination nor the knowledge to direct such enterprises; that "doctors are not equipped to go into the insurance business." Such men assert that, in this sphere, the medical profession should guide—not *initiate;* that its function here is simply to investigate plans, to judge them, and then to make known to all concerned the results of its judging.

Opponents of this philosophy term it impractical. We must initiate plans and operate them, they insist—or lose our identity as independent practitioners.

The school of thought that advocates joint control by hospitals, doctors, and the laity is equally sure of its ground. If joint control is attempted, its adherents say, safeguards can then be adopted which will prevent "freezing out" any one of the triumvirate.

Most physicians seem to agree on the advisability of keeping separate at all times the finances of hospital plans and of medical plans. Most laymen agree that the cooperation of physicians is essential to any prepayment project launched. Opinion on these points, though not unanimous, is almost so.

Then there's the third hurdle: that of determining the provisions and exclusions of each plan.

First of all, should there be free choice of doctor? Most authorities say there should. But definition of the term varies. In most current projects, "free choice" has been modified to mean free choice of any *participating* doctor (may be almost any percentage of the doctors in a community, but seldom all).

What diseases and conditions shall be excluded from the contract? Usually: pre-existing chronic ailments, drug addiction, self-inflicted injuries, etc. Deliveries are also excluded, as a rule, until after ten months. No one who is ill at the time of application is accepted (thus reducing markedly both the scope and risk of the undertaking).

Many authorities state that only about two thirds of all medical and hospital care needed can properly be supplied under prepayment plans. They envision such plans as a means of shouldering only the *major* burdens of illness—the "catastrophic" attacks for which many people, unaided, cannot pay. Minor ailments, it is said, can be financed less expensively by the individual

Reflecting sign makes effective office marker

Can patients find your office after dark?

A shingle that "lights" their way yet needs no electricity is gaining new popularity with physicians.

Constructed on the same principle as reflecting highway signs, its letters are formed of from five to fifteen "jewels" each. They shine like cat's eyes, flash under auto headlights—even reflect light from street lamps.

Cost of such a nameplate depends on the number of letters. Numerals and letters three or four inches high are about 95 cents each; two-inch letters, about 65 cents. The panel for them, including the cost of mounting and a 2½-foot stake, is about $1.50; it is obtainable in black, green, silver, rust, or white finish.

---

out of his own resources than by means of insurance.

Insurance contracts should pay for the services of a physician, they say, only when the patient is confined to his home or to a hospital. Office calls and less important house calls should be paid for by the patient. Only in this way, it is felt, can abuse of the plan by patients be avoided.

The fifth hurdle is that of determining costs.

Medical insurance, it is widely believed, must embrace a deductible provision if it is to be successful (the same type provision as is utilized in deductible automobile-collision insurance). The reason put forth for this, of course, is that a deduction of, say, $10 is bound to discourage trivial, unnecessary calls; it is also certain to cut the cost of the system and to bring it within the reach of more people.

A limit on the liability of each association is also recommended. For example: a limit of $300 per individual per year; a limit of $500 per family.

Many voluntary health insurance advocates shy away from the payment of cash benefits to replace income lost during illness. Many likewise are skeptical of fee schedules which have the disadvantage, they feel, of establishing minimum fees as standard fees in the minds of the public. The present tendency, therefore, is to set up "schedules of benefits" (note terminology)—the benefits being designed to *help* pay the doctor's bill.

Administrative costs comprise another large item. Among group hospitalization plans in the early days, they mounted to as high as 30 per cent; now they average about 9 per cent. Unfortunately, in the field of medical insurance there is scant actuarial background on the basis of which to estimate what administrative costs either will be or should be.

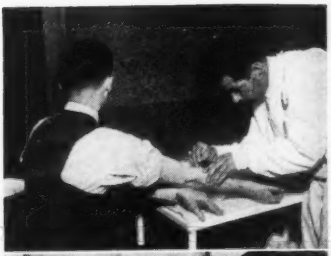
These, then, are the main hurdles. There are others, too.

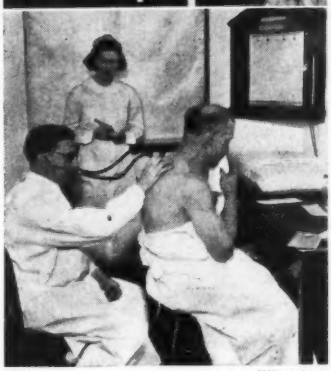
Any medical insurance association that fails to clear them will most certainly, as the English say, "come a cropper."

—WILLIAM ALAN RICHARDSON

They call it RELIEF!

In clinics like these goes on the strangest practice in America —WPA medicine. Here is the truth about Government "aid" to distressed doctors, as investigators for this magazine found it in ten states.





WPA photos

It was in a Texas town. The man looked the MEDICAL ECONOMICS reporter in the eye.

"Sure, I was a doctor once," he declared. "But that was when you could make a living at it. Now I'm a bill collector for a utilities company.

"You might call that ironic. I was forced out of practice because I couldn't collect my own bills. Now I collect other people's."

He added:

"You wouldn't be interested in the story of my two failures in practice, would you? I'll write it for you—for $50."

He seemed disappointed when the reporter said that he would not.

* * *

The sun beat down on Pennsylvania. The road was hot and dusty. The man tried to dig his shovel into the hard earth. He was not a very big man. To get the shovel into the ground, he had to lean on it with all his weight. His thin arms wavered under the load of soil and gravel as he lifted it and tossed it onto the pile beside him.

When addressed, he did not look up. He laid the shovel aside and rubbed his hands with a far-from-white handkerchief. His palms were red. He dabbed at the sweat stream-

ing down his forehead. Then, when he had caught his breath, he spoke.

"I don't want any publicity," he said.

* * *

As the interviewer alighted from the train at New York City's Grand Central Terminal, a colored man stepped forward. His shoulders sagged. But he was very polite and courteous in his manner.

"Carry your bag, sir?" he asked.

On his head he wore a red cap.

* * *

They were doctors once. All of them. Including the porter at Grand Central. Investigators from this magazine found such men in eleven cities in ten states.

Although no one has taken a census, there appear to be scores of them throughout the country. Not the medically indigent, of whom so much is heard, but near-indigent medical men, of whom nothing is heard. The majority are not digging ditches or serving as porters. But all of them have been reduced from the status of self-supporting professional men to that of impoverishment.

From Maine to Alabama, from Manhattan to the Pacific Coast, the stories they stammered when interviewed were the same:

They had experienced no shortage of patients. But times were hard. They had failed to collect. Their landlords did not have the same difficulty. Neither did their butchers or bankers. So—one day, they found themselves on the street, wondering where to go.

The Texas bill-collector was lucky. He was among the resourceful ones who were able to catch on. The first time he lost out was in Texas. He then went east to Tennessee, where he landed a job as a newspaper reporter. When he had accumulated a little money, he once more set himself up in practice.

But after several more years' struggle, he again went broke. Then he walked into his present job, which he intends to keep.

Some physicians are like that. Slapped down by the depression in medicine, they have bounced back in another field—sufficiently, that is, to keep body and soul together.

Take the trio discovered in Bismarck, North Dakota, for instance. From medicine they had turned to pedagogy and liked the change. They had come face to face with enough of the risks of private practice, all three said; they were now going to "stick to something secure."

In several of the States visited, a number of private practitioners were keeping their heads above water through the primitive process of barter. Thomas A. Hendricks, executive secretary of the Indiana Medical Association, told a MEDICAL ECONOMICS correspondent that in his State, this device is common. Said he:

"A number of physicians have mentioned to me that their collections are as low as $3 or $4 a week. If they were not able to take foodstuffs and merchandise in payment in some cases, they would doubtless have to give up the struggle."

This, apparently, is also the case in Alabama, South Carolina, and Texas. Travis County (Texas) has a doctor with a barter system that works like a charm. Although he collected less than $100 in 1938, he lived in reasonable comfort, he related, by swapping his services for everything from food and cloth-

ing to plumbing.

Almost every near-indigent physician interviewed seemed highly skeptical of the one thing supposed to save him, namely; Government relief. Hardships faced the practitioner in many parts of Indiana, Maine, North Dakota, South Carolina, and Texas. But not one doctor contacted in those States had applied for Federal aid. In Minnesota, only two were encountered. The rest were getting along as well as they could.

Only medical men driven by absolute desperation, it was found, would take a Federal handout. And even those who did were constantly looking for some other solution to their difficulty. A Sacramento (Calif.) employment agency, for example, reported the receipt of applications from nearly 100 physicians, now on WPA. These men had begged for private employment of any kind.

A similar situation was found in Pennsylvania. There, a total of seventy-two physicians were reported by the State Employment Service as having enrolled for white-collar jobs.

A brief glimpse at the situation in this State perhaps explains why. None of the seventy-two was actively employed by the WPA at the first of this year. Instead, they were on call by the State for service as nurses, laboratory workers, clerks, and salesmen.

Four other Pennsylvania doctors *were* working on WPA projects. What they were doing was not revealed. In any event, little choice of job is permitted these men, an official in the Public Assistance Department declared, it being mandatory that they accept any work offered—sometimes even manual labor.

In all the United States, there is probably no better place to study what relief means to the doctor than New York City.

There the main medical boulevard—Park Avenue—is lined with prosperous-appearing offices. But in the side streets and slums, the times have taken their toll. Of New York City's medical population, 1.3 per cent—194 physcians—are on WPA.

These men are retained on "educational," "recreational," and "health and clinic service" projects. Thirty are women.

Doctors of all ages are included: 36 per cent are between the ages of thirty and thirty-five; 56 per cent are over thirty-five; 35 per cent over forty; 24 per cent over forty-five; 16 per cent over fifty.

The plight of these professionals is probably the most pitiful in medicine. They are mere cogs in the sprawling machine which creates work for reliefers. Actually, their status amounts to little more than delivery from starvation.

"All a doctor has to do is work for the WPA," a project-director confided, "and his name is ruined."

For, rightly or wrongly, New York patients are much like those anywhere else. If a doctor has to go on relief, they reason, he can't be much good. Once he accepts Uncle Sam's helping hand, the needy physician can kiss many of his remaining patients good-by.

Nevertheless, there is no lack of medical applicants for WPA jobs. WPA authorities in New York assert that they have interviewed "thousands" during the past few years. And even this, they add, is

"no indication of the still larger number in need of assistance." They report having received hundreds of letters from physicians pleading to be placed on relief rolls. Two examples, taken directly from their files, will suffice to show their general tenor. The first reads:

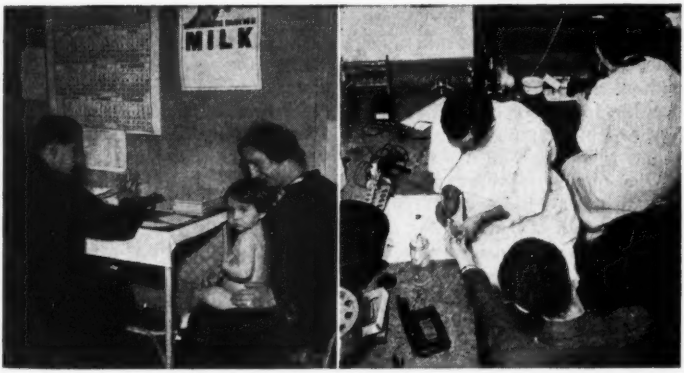
"I was a graduate assistant in the out-patient department of the Massachusetts General Hospital, by appointment. Then followed nine years general practice in Chicago. After that I engaged in medicine in my native Columbus, Ohio. Lack of funds has made it compulsory for me to be separated from my two young daughters. My wife is unable to secure employment. I am very urgently in need of an income to take care of the necessities of living."

The second:

"I am a graduate of a class A medical college. I have been practicing in this State for fifteen years. During the past three years, my practice has so decreased that I am unable to subsist. My former patients now seek treatment at clinics and free hospitals. My foolish pride has kept me from writing to you of my plight. But I no longer have enough to keep body and soul together."

A job as a WPA doctor is not granted, of course, to everyone who writes a heartrending letter. The applicant must be a graduate of a reputable medical school, and a citizen. He must have practiced at least three years and be licensed and registered in his State. And he must be "certified." Which means reporting to the home relief bureau in his neighborhood (where everybody knows him) and swearing that he is penniless. After which he is investigated. If his statements prove true, he will probably be ad-

WPA photos



Family physician to his fellow indigents is the "relief doctor." He guards maternal and child health, carries on the war against venereal disease, and competes with his colleague in private practice—all for a bare subsistence wage of about $22 a week.

mitted to the relief ranks—after a wait of three or four weeks. Then he goes to work for WPA. Provided, however, that a vacancy exists.

As the administrative set-up is political in nature, there are, of course, ways of avoiding the certification stigma. Seventy-four of New York's WPA doctors are uncertified—"recommended," as a WPA official put it, by city departments. Relief bureaus state that these physicians are not paupers.

Why, then, are they on the Government rolls? WPA heads say they "are employed to make possible the continuance of projects giving employment to relief workers in other classifications" and are chosen only "when the lists are completely exhausted of [qualified] physicians."

If this is true, the number of M.D.'s on WPA, ironically, depends neither on the number of needy physicians nor on the number of needy sick. Instead, it depends on the number of "relief workers in other classifications" who can't get along without them! Such a situation, needless to say, represents a condition which, from the medical standpoint, is far from ideal.

One of the Government's first gifts to the novitiate is a number. Then, though still under the technical supervision of a city department, he is assigned to the care of a project supervisor. The latter is often a political-appointee; he may also be a layman. When he cracks the whip, the WPA physician jumps. If he doesn't, he may find himself reported as "incompetent."

Most medical projects in New York City are located in municipal hospitals, public schools, and municipal health centers. Conditions at the latter, it is said, make Great Britain's health insurance organization seem almost ideal. TB patients are lined up and x-rayed ten at a time. VD patients receive their "shots," WPA heads themselves concede, "as fast as the doctors can jab them."

Congress, at its last (76th) session, decided that WPA doctors must work a total of 130 hours a month, just like any ordinary laborer. And in one hour, very often, the relief practitioner sees as many as thirty-five patients. Said one project supervisor: "If a private physician had that kind of practice, he'd make two or three hundred dollars a day!"

Instead, New York's WPA doctors get about $3 a day ($97.50 per month). Formerly, they received slightly more. But when Congress upped the number of hours they must work, it also slashed their wages.

Nor does the WPA physician—unless he's on hand every working day of the year—secure even this wage. For he is not allowed any "sick time." If he is absent for any reason, he must match the lost time hour for hour in "make-up" work—or suffer payroll deductions.

Volume of work done is indicated by figures for a recent month. During that period, New York's WPA physicians gave over 20,000 VD treatments; did 7,000 analyses (urines, spinal taps, Wassermanns, etc.); conducted 13,532 examinations of school children; and wrote 139,843 prescriptions.

If getting on WPA "relief" is difficult, getting back into private practice is almost impossible—though new Federal regulations re-

[*Continued on page 96*]

Indictments by the dozen

The stinging rebuke which Justice James M. Proctor dealt the Administration in its anti-trust suit against organized medicine gladdened the heart of many an independent-thinking physician.

Nevertheless, a word of warning is in order:

Justice Proctor's decision has tended to lull the profession into a state of complacency. Such complacency is ill-founded. For the case is by no means closed. Medicine's status under the indictment remains substantially unchanged. It will not be established conclusively until the U. S. Supreme Court says the final word.

Justice Proctor has, it's true, set a favorable precedent. But precedents are not invariably upheld. Pending the Supreme Court verdict, medicine's cue is to stay on its toes. The struggle to establish our right to practice medicine in the best interests of the public has not ended.

The Administration is continuing its attack on medicine along three fronts: It has appealed its case directly to the Supreme Court. It has appealed concurrently to the District Court of Appeals. While these appeals await action, it may also order a new grand jury to convene for the purpose of serving a new indictment. Obvious reason for calling another grand jury is to try to press charges in some other form if the present indictment is not sustained.

Even though it's possible, it does not seem probable that the Supreme Court will hold the practice of medicine to be a trade. For the Court itself has ruled in the past that learned professions are excluded from the purview of the anti-trust laws. The Court might, however, decide in favor of the Administration on other grounds. What those grounds would be is anyone's guess.

Should the Supreme Court by any chance render an unfavorable verdict, it would mean that physicians could no longer provide medical care according to their best judgment, unless that judgment coincided with the opinion of the Federal Government. Medical societies would be compelled to recognize—even cooperate with—projects typified by Washington's Group Health Association. The Administration would thenceforth have the upper hand in foisting upon the public a system of nationwide compulsory health insurance.

It is not to be inferred that these things will necessarily come to pass. We are optimistic enough to hope they will not. Nevertheless, they are distinct possibilities; so it remains with our legal counsel in Washington to invoke every protective measure at its command.

One heartening sign was the public approbation which greeted the ruling of Justice Proctor. An overwhelming number of newspapers referred to it as "a public triumph." Apparently, the laity recognizes that medicine is not prompted by motives of greed; that it does not oppose sincere at-

tempts to provide voluntary health insurance for those who need it. There appears to be growing understanding of the fact that the physicians of the country seek to eradicate only those plans and schemes which involve coercion, or improper control, or other factors inimical to the public welfare.

How to remove adhesive painlessly

Here's an idea that has saved a lot of skin in taking off large applications of adhesive tape. It occurred to me after watching a philatelist separate a stamp from an envelope.

After loosening a corner of the tape, don't pull the adhesive from the skin. Instead, pull the skin from the tape. After loosening one end, hold it taut; then, with the fingertips, press the skin away from it. Keep repeating this process until, inch by inch, you've removed the entire length.—SAMUEL GIDDING, M.D., Wildwood, N.J.

No doubt a good deal can be said in favor of the drive to enforce the anti-trust laws. It has the certain advantage of discouraging intentional and unprincipled violations. The mistake the Department of Justice made was to choose medicine as the spearhead of its campaign.

That Thurman Arnold—the Administration's middleman and buffer—had as his major objective the "smearing" of the profession can scarcely be doubted. Justice Proctor himself intimated that the entire indictment proceedings had been based on just such a motive.

The boomerang is now becoming apparent. While having succeeded in discrediting the medical profession, Mr. Arnold has also discredited himself. What's more, since the public has an uncanny faculty of seeing through such duplicity Mr. Arnold has lost a certain amount of support for the Adminstration.

The present indictment was drawn up, obviously, because the medical profession would not participate in Administration plans for a socialized medical Utopia. True to type, the Administration could not tolerate dissent. Since there was no law which could be invoked against the profession, an attempt was made to stretch the Sherman Anti-Trust Act to cover medicine's alleged "crime."

Mr. Arnold made his first "boner" when he assumed that physicians would lack the stamina to fight for their rights. He apparently believed that if he thrust a consent decree at them, they would accept it rather than risk being fined and imprisoned. His bluff didn't work.

Mr. Arnold also made the blunder—inexcusable in political strategy—of underestimating his opponents. Not only did they refuse to be browbeaten, but they have won a preliminary victory which is sure to encourage others who may be similarly threatened.

Mr. Arnold's anxiety to obtain a consent decree gives substance to the belief that he never did feel confident of proving that organized medicine had violated the Sherman Act. Which, in turn, is a basis for the opinion that the Administration's sole purpose was to bully the profession into submission, thus breaking down opposition to its projected goal of compulsory health insurance.

So far, Mr. Arnold has lost. In the Supreme Court there's at least a fair chance that he will lose again.

Instead of admitting a personal and somewhat childish resentment by appealing the case, he and the forces for whom he works might better, in their own interests, have accepted defeat quietly and kept their mouths shut.—H. SHERIDAN BAKETEL, M.D.

Too True

"Thank you so much for making me well again, Doctor. I'll be indebted to you for life!"

A 'happy-medium' case-history form

BY MALCOLM C. DAVIS

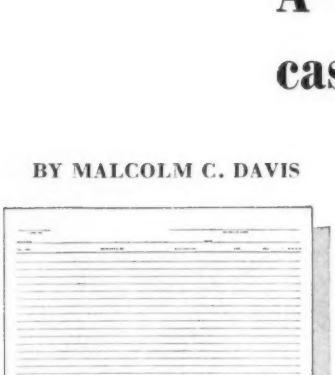


FIG. 1

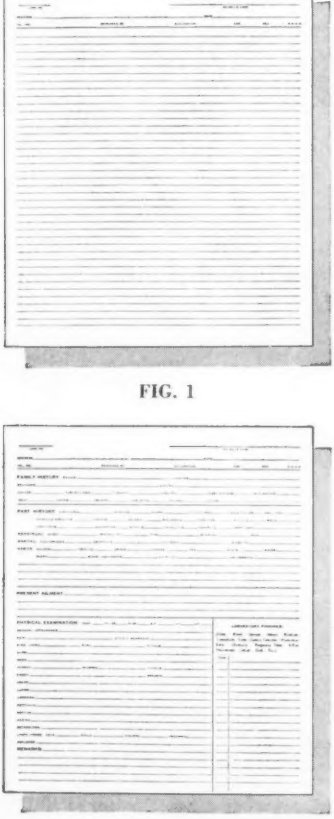


FIG. 2

Thinking of revamping your case-record system? Or of setting up a new one?

If you are, don't neglect to consider *all* the types of record forms now available. For the right one, suited to your particular needs, will save incalculable time and trouble.

After you've decided whether you want to keep your case records on cards or sheets, of what material and size they will be, and how you will file them, the next question is:

What printed matter should appear on the forms?

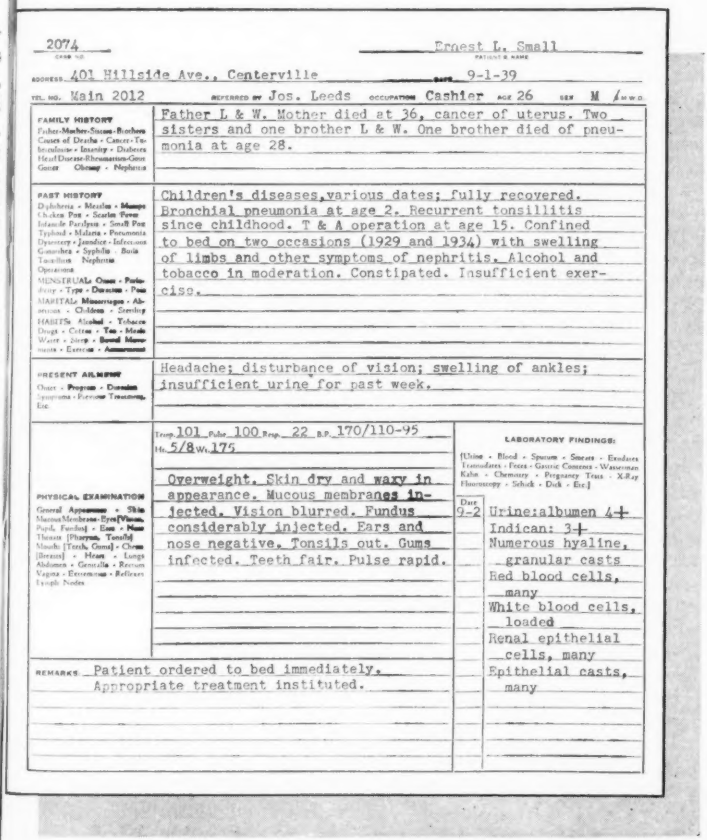
Here, your choice lies between the type that carries little or no printing at all (Fig. 1) and the form which has headings and blanks for virtually everything (Fig. 2).

The form without printing has the advantage of plenty of space in which to write. But since there are no headings, you *may* forget to record some of the essential facts. This form also requires a lot of writing, and is, therefore, more of an effort- and time-consumer.

What about the form with many headings? This has the advantage of reminding you to enter all the important details. But because the printed headings take up so much room, you may find your writing space cramped. This is not always so, of course; and it must be admitted that, generally, of the two forms, the one with headings is to be preferred.

To bridge the gap between these extremes, a New York printer has now introduced the "happy-medium" form shown in Fig 3. To some extent, the new form combines the advantages of the two already described; for it provides a fair amount of writing space and, at the same time, includes a column of headings to jog the physician's memory.

The particular form illustrated is printed on an 8″ x 9½″ card which folds, for filing, to the standard 5″ x 8″ size. On the back are spaces for diagnosis, treatment, the financial record, and subsequent visits and findings.



2074 (CASE NO.) — Ernest L. Small (PATIENT'S NAME)

ADDRESS 401 Hillside Ave., Centerville — DATE 9-1-39

TEL. NO. Main 2012 — REFERRED BY Jos. Leeds — OCCUPATION Cashier — AGE 26 — SEX M (M. W. D.)

FAMILY HISTORY (Father-Mother-Sisters-Brothers · Causes of Deaths · Cancer-Tuberculosis · Insanity · Diabetes · Heart Disease-Rheumatism-Gout · Goitre · Obesity · Nephritis)

Father L & W. Mother died at 36, cancer of uterus. Two sisters and one brother L & W. One brother died of pneumonia at age 28.

PAST HISTORY (Diphtheria · Measles · Mumps · Chicken Pox · Scarlet Fever · Infantile Paralysis · Small Pox · Typhoid · Malaria · Pneumonia · Dysentery · Jaundice · Infections · Gonorrhea · Syphilis · Boils · Tuberculosis · Nephritis · Operations · MENSTRUAL: Onset · Periodicity · Type · Duration · Pain · MARITAL: Miscarriages · Abortions · Children · Sterility · HABITS: Alcohol · Tobacco · Drugs · Coffee · Tea · Meals · Weight · Sleep · Bowel Movements · Exercise · Appetite)

Children's diseases, various dates; fully recovered. Bronchial pneumonia at age 2. Recurrent tonsillitis since childhood. T & A operation at age 15. Confined to bed on two occasions (1929 and 1934) with swelling of limbs and other symptoms of nephritis. Alcohol and tobacco in moderation. Constipated. Insufficient exercise.

PRESENT AILMENT (Onset · Progress · Duration · Symptoms · Previous Treatment, Etc.)

Headache; disturbance of vision; swelling of ankles; insufficient urine for past week.

PHYSICAL EXAMINATION (General Appearance · Skin · Mucous Membrane · Eyes [Vision, Pupil, Fundus] · Ears · Nose · Throat [Pharynx, Tonsils] · Mouth: [Teeth, Gums] · Chest [Breasts] · Heart · Lungs · Abdomen · Genitalia · Rectum · Vagina · Extremities · Reflexes · Lymph Nodes)

Temp. 101 Pulse 100 Resp. 22 B.P. 170/110-95
Ht. 5/8 Wt. 175

Overweight. Skin dry and waxy in appearance. Mucous membranes injected. Vision blurred. Fundus considerably injected. Ears and nose negative. Tonsils out. Gums infected. Teeth fair. Pulse rapid.

LABORATORY FINDINGS: (Urine · Blood · Sputum · Smears · Exudates · Transudates · Feces · Gastric Contents · Wassermann · Kahn · Chemistry · Pregnancy Tests · X-Ray · Fluoroscopy · Schick · Dick · Etc.)

Date	
9-2	Urine: albumen 4+
	Indican: 3+
	Numerous hyaline, granular casts
	Red blood cells, many
	White blood cells, loaded
	Renal epithelial cells, many
	Epithelial casts, many

REMARKS: Patient ordered to bed immediately. Appropriate treatment instituted.

Courtesy, Professional Printing Co.

FIG. 3

Help for the hospital staff

Outlining some of the friction points in the doctor-hospital relationship and how they can be lubricated

JOHN REEVES, M.D.

In his own office or in the patient's home, the attending physician is the unchallenged captain of the sick man's crew.

Not so in the hospital. There responsibility is divided among interns, nurses, technicians, consultants. The attending physician is too often but a co-worker at best, a rule-regimented assistant at worst.

It is time for the physician to pause and review his relationship with the hospital. Thoughtful stock-taking now will lubricate the friction points that arise inevitably when a growing institution crowds against an individual interest.

Ponton*, in a new book, analyzes this entire subject with masterful thoroughness. Physicians everywhere will find his observations both helpful and enlightening.

First let it be remembered that, valuable as hospitals are, *they* need the doctor more than the doctor needs *them*. A zealous practitioner can treat illness and guard public health even without the aid of the hospital. Thousands of doctors have done so and will continue to do so.

But a doctorless hospital is impossible.

The humility with which many doctors plead for staff appointments and the gratitude with which they accept them lends color to the feeling that a hospital does a physician a favor by appointing him to its staff. Yet as Ponton (himself a hospital administrator) says:

"In granting appointments, no favor is conferred. For the hospital cannot exist without its staff."

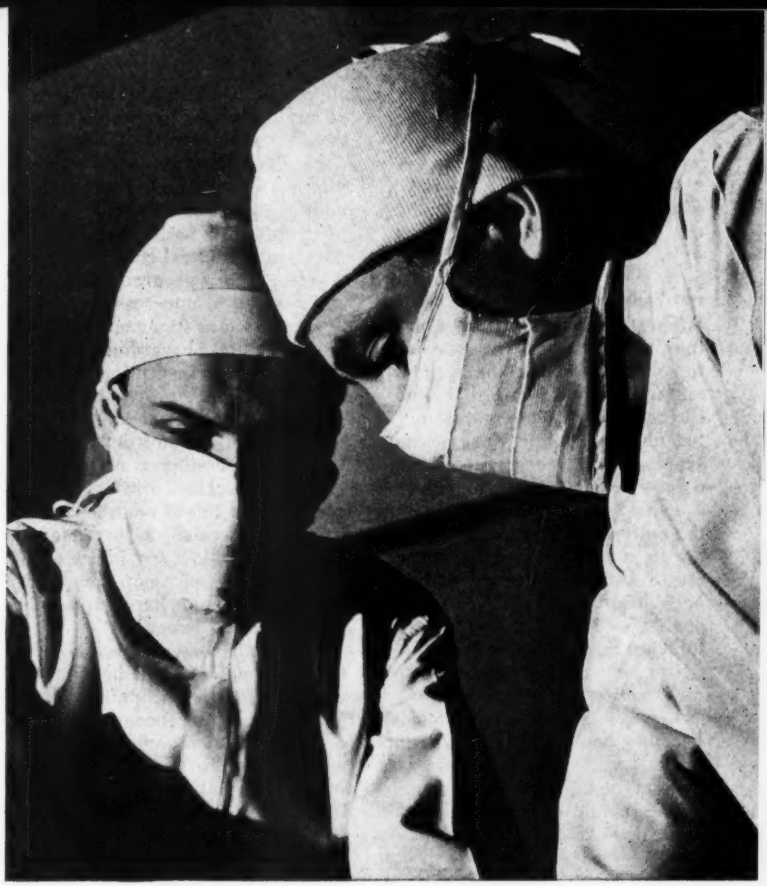
Nor should the physician forget that the hospital's annual plea for communal support rests not on the institution's services, but on the physicians' services. "Support the X Hospital," bellows the publicity. "It treats the sick without regard to color or creed. It gave 10,000 days free care last year. Etc., etc."

But *who* treated the sick? *Who* gave the free care? Not the bricks and stones of the building. Nor the paid administrative staff. The doctors gave it . . . Yet so inept have physicians been in the art of publicity, that hospitals are hailed as models of selfless public spirit, while the physician is popularly portrayed as part of a money-grabbing medical "trust."

Hospital leadership is—or should be—largely in the hands of the medical chiefs, the attending physicians and surgeons who constitute the senior staff. The conscientious chief will periodically review his relations with his junior physicians, with the administration, with the nursing staff.

Take the matter of building an

*Ponton, Thomas R. "The Medical Staff in the Hospital." Published 1939 by the Physicians Record Company, Chicago.



Ewing Galloway

esprit de corps within a service, for instance. In some institutions, a service is a loose group of individual practitioners, each swinging in his own orbit, integrated only on paper into a single specialized unit. Jealousy, friction and politics are inevitable under such chaotic conditions.

One method of weaving these individuals into a unified staff is to maintain service conferences. The doctors on the service meet—perhaps once a month—in the home of their chief. The setting is conducive to neighborliness, not rivalry. The review of the state of the service encourages the faithful and stimulates the laggards. The calibre of the treatment offered is evaluated. Scientific lessons are distilled out of the experience of the service. It's a prime device not only for graduate education but also for easing the

irritations produced by intra-hospital conflict.

Incidentally, a thoughtful chief labels his subordinates collectively as "my associate staff," not as "my junior staff." The latter phrase carries an unjust implication of inferiority and inexperience.

An alert staff man knows the value of adequate hospital records, too. When the record librarian urges the physician to write progress notes, to polish his medical nomenclature, and to supply missing chart items, she isn't merely going through a perfunctory routine. Soon or later, every doctor discovers the four-fold value of a good chart, namely:

It furnishes a compact picture of the patient's condition. It gives the doctor a head start when he first sees a patient who has previously been hospitalized. It's a concrete contribution to the attending doctor's graduate education. And, finally, it's a life-saving exhibit in a malpractice action.

Properly handled, the hospital becomes the physician's servant, not his master. At that stage the doctor gives a thought to the protection of the institution's reputation. Let the hospital acquire a bad name, and every physician whose shingle appears on the staff directory in the lobby is going to suffer.

How can the staff contribute to the hospital's reputation? First, by seeing that no operation or radical medical treatment is undertaken without indications that will bear the criticism of the rest of the staff. In some institutions, a pre-operative consultation by a surgical chief is the rule.

Some hospitals prescribe a release which patients admitted in incomplete abortion must sign. It clears both the hospital and its staff of any blame for having procured the abortion originally.

Finally, the wide-awake staff places all treatment procedures—both medical and surgical—on the program for possible review and criticism at general staff meetings. A year of such a program will purge any hospital of unnecessary operations, suspicious treatments, or other procedures hazardous to the standing of the institution.

Probably the sorest point in institution-individual relationship is the status of the hospital's roentgenologist, anesthetist, or pathologist. If he receives a salary, a cry goes up that this is contract medicine. If he receives a fee for each service, his fellow specialists complain that he is competing with them without being handicapped by their overhead expenses.

To hurdle these obstacles, Ponton suggests that the hospital-attached specialist be paid a fixed percentage of the income from his X-ray department, anesthesia service, or laboratory. This gives him incentive to improve the quality of his work, assigns him his share of free service to ward patients, and reduces the objectionable features of a fee-for-service system.

One more battle-field: departmental demarcation. When is an appendectomy in a female sent to the gynecologic service, when to the surgical? Do the orthopedists or the surgeons handle fracture cases? The staff that yearns for trouble-free tenure will do well to call a conference to draw the frontiers of the specialties. Better that way than have the lay trustees issue a dictum to quiet quarrels when doctors disagree.

WHAT DO YOU KNOW ABOUT THAT?

1. To satisfy legal requirements, consent to an operation should be:

   A. Written B. Oral C. Implied D. Any of these

2. The United States Pharmacopeia is sponsored and authorized by:

   A. The U.S. Pharmacopeial Convention
   B. The American Pharmacopeial Union
   C. The American Pharmaceutical Assn.
   D. The A.M.A.
   E. The U.S. Government
   F. The W. B. Saunders Co.

3. Abortions performed daily in this country are estimated to total:

   A. 50 B. 100 C. 500 D. 400 E. 300 F. 650 G. 1,000 H. 1,200

4. You're not required to pay A.M.A. Fellowship dues if you are:

   A. A.M.A. president
   B. On home relief
   C. An A.M.A. delegate
   D. An A.M.A. trustee
   E. An army doctor
   F. A health officer

5. To support a 100-bed hospital usually requires a population of about:

   A. 10,000 B. 25,000 C. 50,000 D. 75,000 E. 100,000 F. 200,000

6. History tells us that bloodpressure was first measured by:

   A. William Harvey B. Stephen Hale C. Jan Sphygmo D. Eugene Tycos

7. Proportion of autopsies required in an A.M.A.-approved hospital is:

   A. 10% B. 25% C. 20% D. 50% E. 15% F. 35% G. 75% H. 84% I. 100%

[*Answers on page* 68]

Real estate

Sociologists approve them as an escape from costly, crowded living. For realtors, they have obvious charms. To many average American families, they spell a fresh start in a brand-new, growing community.

But what about the private practitioner? What message do real estate developments hold for him? Are they worth looking into as location possibilities?

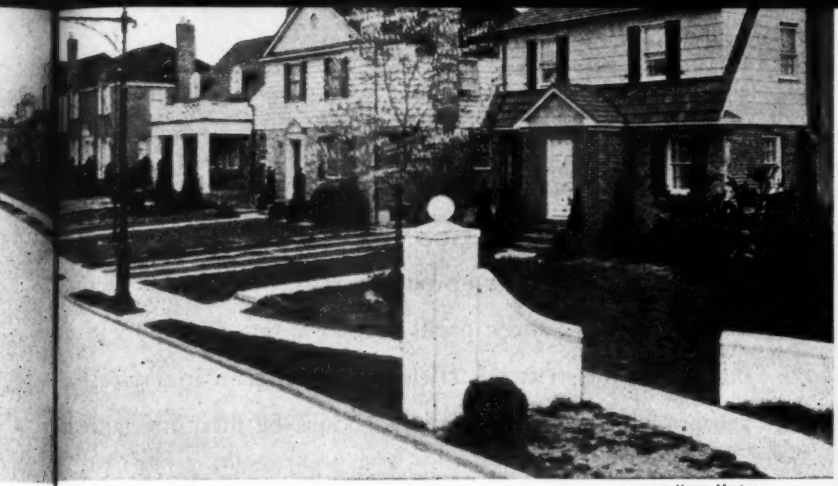
Generally speaking—yes. Their popularity is steadily increasing. Which means that increasing numbers of clinic-less areas are being opened to private practice. And their residents have at least a degree of financial stability . . . All in all, the perfect answer, you may think, to that yearning for an old-fashioned family practice, without the inconveniences.

Rather than accept this optimistic guess as fact, MEDICAL ECONOMICS decided to investigate.

A visit to several representative developments indicates, first of all, that they are not always the garden spots described in the advertisements. They are a special type of community. And they have special problems. A good many of these may turn out to be disadvantages to the location-hunter.

The study shows, further, that practices in new-housing areas demand unusually careful management. They often require a capital reserve at the start. And they do not offer rewards as great as those found in some other fields.

There is no such thing as a standard type of development. They vary according to their size, locality, type of tenant, and a score of other factors. Some are "experimental"; others, "non-profit"; most are frankly commercial. They have been sponsored by the Government, by philanthropic foundations, by in-



Courtesy, Gross-Morton

developments— A BED OF ROSES?

IT ALL DEPENDS . .

dustrial firms, by life insurance companies, by private speculators —even by labor unions. And with varying degrees of success.

The catalog of their differences could be continued indefinitely. But far more significant is one point which all developments have in common:

They concentrate, within geographical areas, patients who usually can afford private care.

Usually is the right word. There are exceptions. One is the housing project where rentals or carrying charges average less than $30 a month per tenant. It is almost always government-subsidized. Its tenants, largely indigent or near-indigent, obtain their treatment at clinics.

At the other extreme is the development made up of homes in the $100-a-month-and-up class. Needless to say, such developments are comparatively few in number. And they're not always worth the expensive investment required of a physician.

This may seem hard to believe. But houses of this type are often country homes, occupied only a few weeks during the year. Even when stricken on the premises, their owners tend to call in outside specialists.

The doctor's best bet is usually in the $30-to-$100-a-month development. People who rent homes in this price-scale are ordinarily his

IN DEPRESSIVE STATES, Benzedrine Sulfate Tablets will often produce a sense of increased energy, mental alertness and capacity for work, but should be used only under the strict supervision of a physician. In depressive psychopathic states, the patient should be institutionalized.

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BENZEDRINE SULFATE TABLETS

Each 'Benzedrine Sulfate Tablet' contains amphetamine sulfate, 10 mg. (approximately ⅙ gr.)

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

Established 1841

most desirable patients.

Furthermore, on the basis of U.S. Department of Labor statistics, it is estimated that at least 90 per cent of all real estate developments fall into this classification.

But don't post your shingle in *any* development before asking yourself this question:

Am I fitted for this sort of work?

Judging from the communities toured by MEDICAL ECONOMICS reporters, only general practitioners stand a fifty-fifty chance in this field. Because of their high proportion of pediatric cases, the physicians interviewed considered some training in this specialty a valuable asset. But they confirmed the opinion that, in localities like theirs, a full specialist would "starve to death." Only one specialist was encountered—and he had been forced back into general practice.

Temperament also plays its part in determining your adaptability to development practice. The saying, "birds of a feather flock together," is nowhere more true than in these small communities. Better make certain before settling in one that its people are "your type."

Otherwise, you may react as did one doctor interviewed. He had quit a development—where he was doing fairly well financially—because he couldn't get any satisfaction out of his work there. He had an ingrained distaste for the young, not-too-brilliant, white-collar class who composed the entire population of this particular colony. Instead of arousing his sympathy, their troubles, he discovered, only irritated him. So he left—but not until he had wasted considerable time and money attempting to gain something he didn't want.

Now it's time to turn the question of qualifications about, and inquire:

Can this community support me in the style to which I would like to become accustomed?

No one can foretell infallibly whether Cuddly Acres, Inc. is destined to become the "city of tomorrow," as its billboards prophesy, or just another "ghost town." Nevertheless, it pays to study local conditions. You should have some idea

Streamlined fees boost rural visits

Improved roads and highways have removed the last excuse for the traditional dollar-a-mile charge for rural home visits. I am convinced every modern practitioner should wish it good riddance.

My "territory" extends fourteen miles in almost every direction from my office. But until recently, I received few calls beyond the six-mile limit.

To find out why, I dropped in on a few of the distant families I knew. To my queries, they replied that a dollar a mile placed my services beyond their means.

Yet almost all agreed they would willingly pay $5 for a home call!

So I revised my fee schedule. Calls within three miles are now $3; beyond that, $5.

The new system has eliminated disputes about my speedometer's accuracy. And I now receive several times the number of long calls I did formerly. The change has built up good will and brought me many new patients.—ALLEN D. REBO, M.D., Scott, Arkansas.

of what sort of basket your eggs are going into.

The best place to obtain authentic information about a development is *not* the office of its agent. A talk with this gentleman is both necessary and informative. But the facts and figures he will give you are valuable mainly for purposes of *comparison.*

They should be checked and double-checked by every means at your command. Personally examine the property and its environs. Talk with residents, both present and past. Discuss problems of financing with colleagues established in similar situations. Get a map that will show you the position of adjacent towns and highways. If possible, have somebody who understands the details of construction and planning—preferably an architect or builder—look over the property. By all means, let your wife scout the neighborhood. Her woman's instinct may turn up a dozen objections the others overlooked.

This inspection can't be too thorough. In talking with physicians who practice in developments, MEDICAL ECONOMICS discovered a number who confessed to thorough disillusionment. True, they *have* survived. But their experience varies widely from the prospects outlined by realtors.

The latter, it seems, tend to puff the incomes of their tenants, in the belief that this gives their community "class." In several cases, estimates of patients' income—by physicians who had resided in the communities for at least six years—turned out to be less than half the figures quoted at the real estate office.

Promoters' predictions of the possibilities for community expansion were also inclined to be rose-colored. In one instance, a physician was led to believe—with the help of blue prints and an artist's sketch of an imaginary city—that the population of a newborn development would climb rapidly to the 25,000 mark. After eight years, the community has 1,400 people—which isn't, incidentally, at all bad.

Sadder was the fate of the doctor who bought a house on the strength of a promise that a local road would connect with a nearby metropolis. That was ten years ago. Today the road extends exactly two blocks, coming to a dead end in the middle of some woods.

If the development consists of apartment buildings, you are less likely to be led astray on the matter of overhead. Practically all your housing costs are included in the rent. How easily the budget for maintaining a house can be upset by unexpected extras, however, is fully appreciated only by those who have been through it.

The moral is:

Rent first, if you can; buy later when the pudding has proved itself.

In any study of this nature, a

IRON *is how you find it*

Abundant clinical evidence cites the superiority of iron in the ferrous form, particularly ferrous carbonate. A wealth of literature attests the greater utilization of iron when combined with copper as a catalyst.

"FERRO-CATALYTIC" is

THE ORIGINAL IRON COPPER PREPARATION

with the maximum utilization of iron (as ferrous carbonate) for the treatment of Secondary Anemias.

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"FERRO-CATALYTIC" CAPSULE No. 83 "FROSST"

(basis for all Ferro-Catalytic formulas)

Ferrous carbonate.....6¾ gr.
Copper (as carbonate).....1/48 gr.

"FERRO-CATALYTIC" COMPOUND CAPSULE No. 668 "FROSST"

Ferrous carbonate.....3⅜ gr.
Copper (as carbonate).....1/96 gr.
Vitamin B_1 crystals (antineuritic vitamin)..1/4000 gr.
Nicotinic Acid (pellagra preventive vitamin) .....1/24 gr.
Extract Cascara .....¼ gr.

Kindly send me, for Clinical Trial, without charge or obligation:

1. Standard full-sized package of Capsule No. ..... "Frosst".
2. Hemoglobin Scale.
3. Resume of Iron Therapy in 16 pages with complete list of formulas available.

(Print)
Name .....

Address .....

City ..... *State* .....

ME-9

number of other factors should also be considered.

First of these is the size of the development. It's impossible to say how many patients will be required to support a practice. Too much depends on your standards and on the economic level of your patients. But it may be helpful to remember that the average U.S. physician can call about 750 patients his own. In a development, this fact cannot alone be considered a guide. It must be evaluated in the light of the following elements:

Is the development annexed to, or within a stone's throw of communities already established? And is there a hospital near at hand?

If the answer is yes, you may be able to count on extra sources of practice. But—remember—a nearby town or city is also apt to be a center from which competition will emanate.

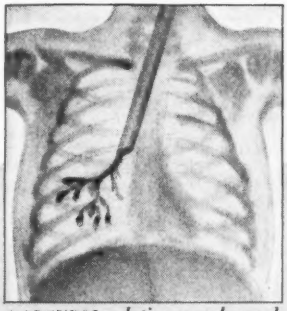
This suggests a method of eating your cake and having it, too. If a development springs up near your community, you may find it profitable to practice there without residing there. This is most likely to be true where the new homes are comparatively few in number. It's also a way of hedging against an uncertain future in the project. Many doctors are doing this successfully, hanging onto their previous practices.

From the viewpoint of the physician who rests his entire future with the development, on the other hand, outside competition is often a veritable *bête noir*. Serious cases are sent frequently to a nearby city for attention. In the communities surveyed, local practitioners get a large percentage of emergency and minor treatments. But much surgery, and most of the OB work, goes outside.

Obviously, a development won't support you from the very first. Which means that some capital reserve is a practical necessity. If you buy a house (not advisable until you prove the worth of your location), a down payment will, of course, be required. Even if you rent, you can expect a fairly long wait until enough families move in to support a physician. Should you try to avoid this initial expense by moving in *after* your potential patients have done so, you may discover that a competitor has gotten the jump on you.

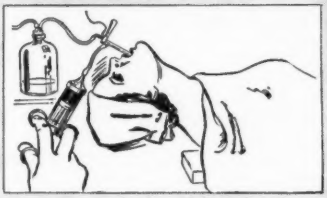
In the communities visited, it was almost three years before the average practice could stand on its own feet. To survive this test period

BRONCHOSCOPIC SUCTION-IRRIGATION



WITH

ARGYROL



● ARGYROL *solution may be used with great effectiveness in the treatment of chronic pulmonary suppuration through the aspirating bronchoscope or the Jackson aspirating tube.* In this X-ray picture the bronchoscope is shown in place; the bronchiectatic dilatations demarcated by lipiodol.*

The purulent material is removed from the cavity by suction. A one per cent ARGYROL *solution, 10 to 30 c.c., is then introduced, the suction continuing all the while. Such therapy frequently causes an immediate decrease in the secretion and in the odor.*

The prompt improvement which commonly follows suction irrigation of bronchiectatic cavities or pulmonary abscesses with ARGYROL is striking evidence of ARGYROL'S unique therapeutic properties. ARGYROL appears to have a remarkable propensity for allaying inflammation and clearing up infections of the respiratory tract. In rhinitis, sinusitis, pharyngitis, tonsillitis, laryngitis and other conditions, gratifying improvement is observed when genuine ARGYROL "Barnes" is used.

ARGYROL, the original mild silver protein, differs chemically and physically from its imitations. Its colloidal dispersion is finer; its Brownian movement more active. Its pH and pAg are specially adjusted to delicate mucous membranes. Now the new ARGYROL packaging always assures freshness of solution; accuracy of concentration; protection from light, moisture, and contamination. For best results, specify the "ORIGINAL ARGYROL PACKAGE," when ordering or prescribing.

**Jackson, Chevalier: Bronchoscopy, and Esophagoscopy, Saunders, 1927; p. 304.*

INSURE YOUR RESULTS . . SPECIFY THE

ORIGINAL ARGYROL PACKAGE

A. C. BARNES COMPANY • NEW BRUNSWICK, N. J.

FOR 38 YEARS SOLE MAKERS OF ARGYROL AND OVOFERRIN

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without a private income, you can depend on only one alternative—a supplementary means of support.

For the vast majority, the latter is the only solution. Some find such partial support in a position with an insurance company, in compensation work, as local health officer, as school physician, or in a second private practice in a nearby city.

The number of children being the potent factor it is in determining the amount of practice available, you probably won't fail to inquire into the probable size of the average family in the community. Generally speaking, a youthful community is to be preferred. While the ratio of children per family may be comparatively low, this is no indication that they may not soon surpass their elders in this respect. Moreover, it is probable that fewer of the young people will have acquired family physicians.

Against this advantage, however, the development doctor may have to be satisfied with a smaller volume of cases. On the basis of conditions in the communities studied by MEDICAL ECONOMICS, it would appear that the average doctor cannot expect to earn as much as his colleagues in larger communities.

However, to the man who is "not out for money alone," as one physician put it, this type of practice has its compensations.

Particularly in self-contained developments, collection worries are few and far between. In such small groups, deadbeats are quickly tagged—and handled accordingly. Furthermore, the scale or rental of homes in developments is a strictly cash-and-carry proposition. When a resident can no longer meet his rent or payments, out he goes. Thus, the indigent are eliminated by a continued survival-of-the-fittest process. To illustrate how rigorous this can be: In a New Jersey community where 60 per cent of the original purchasers lost their homes in six years, less than one per cent of all medical care consisted of charity cases.

If development residents pay their doctors' bills, however, they generally pay them slower than elsewhere. The example just cited is evidence that these families are inclined to over-mortgage themselves and live beyond their means. With the result that the physician—as usual—is the last to be paid.

On the brighter side, developments can boast several points of sovereignty. As previously mentioned, there is little or no serious competition from clinics. Where the location is sufficiently out in the open, the majority of patients are not in a mad dash to the country—thereby lessening the Summer slump. Some of the larger communities have organized social programs and clubs that are excellent points of contact with potential patients.

One alert doctor, for example, has won practically his entire com-

You won't need a Safari to carry the new G-E Mobile-Portable Unit

Here's a mobile-portable x-ray unit that's so compact it can be packed in two attractive cases; so lightweight and easy-to-carry that a single trip takes the whole outfit from office to car! It's the unique G-E Model F-3-35 which combines the popular Model F-3 portable x-ray unit with the new Model 35 mobile-portable tube stand.

All around it's an ideal unit for the medical man who does not have adequate roentgenological service readily available. It provides flexibility and accurate adjustment in a thoroughly practical office mobile unit that can be "knocked down," packed up, and immediately converted to a portable unit without limiting its flexibility or wide range of service.

To best evaluate this fine unit, see it yourself. We will be glad to arrange an interesting working demonstration for you, in your office, at your convenience. Just sign and mail the handy coupon, today.

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☐ Check here and we will arrange with you for an interesting demonstration of the F-3-35 in your office.

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NAME .....

ADDRESS .....

CITY .....

A29

munity to his side by waging a one-man health campaign. Hearing that lecturers were being engaged to address residents once a week on various subjects, he offered to deliver a medical talk without charge. It proved so popular that it has now become a permanent feature.

It is hardly necessary to point out the wisdom of participating in such activities. But it can be overdone. Some of the physicians in communities visited admitted that they had paid in lost practice for being overzealous in this respect. Their positions as civic leaders had forced them to take sides in local disputes, thus bringing upon themselves the ill-will of the losers and suffering, through too much familiarity, in the opinion of the others.

Beyond the immediate medical-economic advantages, there are certain other satisfactions to life in a development. If you have children, there may be special accommodations for them, such as bicycle paths, tennis courts, swimming pools, baseball diamonds, and even indoor recreation centers. Your patients are bunched conveniently near your office, so that little tiresome traveling is necessary. Finally, the doctor-patient relationship—as observed in the communities covered—is closer.

Perhaps the sense of general satisfaction that results from a successful development practice is best expressed by the doctor who said:

"I've practiced in the city and I know what it is. Out here I'm my own boss. I don't make a fortune; but I enjoy life. I have a fine home and a garden, a healthful environment for my family, and a leading place in the community. What else could I want? Frankly, I wouldn't

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THE SEAL which you see above is emblematic of the resources of men, money and years devoted to the cause of making available Vitamin D products of unquestioned worth and deserving of your full confidence. Every licensee of the Foundation is entitled to use this Seal on its licensed products; *and every product licensed by the Foundation is periodically tested, whether or not the Seal appears thereon.* This Seal or other reference to the Foundation on the package of, or any advertising matter relating to any Foundation-licensed Vitamin D product is added assurance of standard and uniform potency.

All of the licensed companies with facilities for determining Vitamin D potency make regular tests of their own products. In addition, they send samples to the Foundation's laboratory for periodic bio-assays, because the integrity of their products and the prophylactic and therapeutic claims made for them are the keystones of the deserved confidence they maintain.

Further control of Vitamin D potency comes through "over-the-counter" purchases of the products by Foundation representatives who send them in for bio-assay. Vitamin D fluid milks are tested by the Foundation or by one of nine other laboratories in different parts of the United States and Canada, which have been approved by proper State or municipal authorities and by the Foundation.

Because control of the product is a measure of its reliability, the Foundation's control is rigid. It is control of this kind that you, who prescribe or advise the use of Vitamin D products, can rely upon. It is the type of control that is a mark of merit for those products that carry the Foundation's Seal, or make reference to its name.

More than $300,000 has been devoted by the Foundation to experiments and research to perfect the technique of irradiation; to determine the human value of Foundation-licensed products; and to assure uniformity of their Vitamin D potency.

An equal or greater amount has been utilized for similar work by the companies licensed to use the Steenbock Irradiation Process.

About the FOUNDATION . . .

The Wisconsin Alumni Research Foundation was organized in 1925 to accept and develop voluntarily assigned discoveries and inventions of a patentable nature made at the University of Wisconsin. All net avails resulting from licensing arrangements are made available to the University and are dedicated to research in the natural sciences. The Trustees of the Foundation, all of whom are alumni, render gratuitously a most valuable service to the Foundation and to their Alma Mater.

The first discovery assigned to the Foundation was announced by Dr. Harry Steenbock in 1924. He demonstrated how Vitamin D is synthesized in certain foods and chemicals by ultraviolet irradiation, and indicated the benefits to human welfare that could be realized through the application of his discovery. No licenses for the use of the method were granted until careful experimentation and research had determined the value of the irradiated products.

Subsequently several other discoveries have been assigned to the Foundation.

A more detailed account of the Foundation's history, purposes and work is contained in the pamphlet, "Scholars from Dollars," a copy of which will be sent to you upon request.

WISCONSIN ALUMNI RESEARCH FOUNDATION, MADISON, WISCONSIN

trade my practice with that of any colleague with ten times my income."

Practice in a development may be no bed of roses. But it is not necessarily one of thorns, either. While the income it offers is necessarily limited, it has solid virtues that are winning it a growing body of adherents.—ARTHUR J. GEIGER

Frank appeal spurs collections

Payment prompted by this straightforward letter

Want to collect without creating hard feelings?

Then try the friendly but compelling letter which follows. I have found it remarkably effective, especially in rural communities:

Dear Mr. Smith:

I regret having to mention again the $24 due for services rendered last May. But I hardly feel that it is fair for me to wait any longer.

You probably don't realize how promptly my creditors expect me to meet *my* obligations. They never fail to let me know when thirty days are up.

This is the only part of medical practice I don't like—asking people for money. It's especially embarrassing when I know folks personally, as I do you; and when I know they are "good" and have every intention of paying eventually. Still, I simply can't let bills run indefinitely if I'm to meet my own with reasonable promptness.

I enclose a stamped envelope. Won't you please let me have your check by return mail? I guarantee it will be put into immediate circulation!—ALLEN D. REBO, M.D., Scott, Ark.

. . . From the Laboratories which originated WHITE'S COD LIVER OIL CONCENTRATE

HERE are products of the same integrity, efficacy and ethical character that you have found typical of White's Vitamin A and D products. White's Vitamin B products contain definite amounts of Thiamin and Riboflavin. In addition, however, all the other B Complex factors are present. Further, you will doubtless appreciate the fact that the B Complex is available in both *Liquid* and *Tablet* form.

Your patient, too, will welcome the pleasing flavor, convenience and economy of these potent members of the important vitamin B Group.

Your preferred pharmacy is now prepared to fill prescriptions for White's Vitamin B products, or can immediately procure these products for you:

VITAMIN B COMPLEX CONCENTRATE LIQUID

Pleasantly flavored. 6 drops, or one-tenth of a cc. contain not less than 50 International Units of B_1 (Thiamin); not less than 10 Sherman Bourquin Units of G (Riboflavin). Also, significant amounts of all other natural B complex factors.

Available in bottles (with droppers) of 5 cc. and 25 cc.

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Each tablet contains not less than 50 International Units of B_1 (Thiamin); not less than 15 Sherman Bourquin Units of G (Riboflavin). Also, significant amounts of all other natural B complex factors.

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THIAMIN CHLORIDE

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Each tablet contains not less than 300 International Units of vitamin B_1.

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Each capsule contains not less than 9,360 U.S.P. units of vitamin A; 936 U.S.P. units of vitamin D; 27 International units of vitamin B_1 (Thiamin); 10 Sherman Bourquin units of vitamin G (Riboflavin), and, in addition, significant amounts of all other natural B Complex factors. In both vitamin A and D content each capsule is equivalent to not less than 3 teaspoonfuls of cod liver oil meeting U.S.P. Minimum Standards.

Available in sanitaped packages of 24, bottles of 100.

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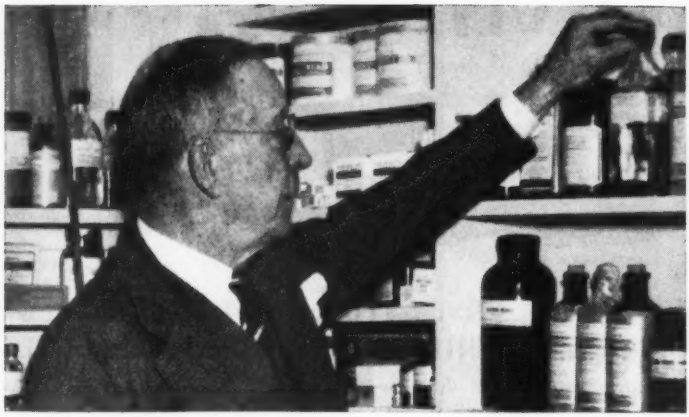

Why I quit the G.H.A.

BY HENRY ROLF BROWN, M.D.

I was the first medical director of the Group Health Association in Washington, whose existence was responsible for one of the most fantastic legal moves ever made by the United States Government: criminal prosecution of the American Medical Association and of some of the most eminent and upright members of the profession.

The story I am about to tell should be investigated by a Congressional committee, for it relates to the diversion of public funds for purposes unauthorized by Congress. Similar activities have merited the term, "graft."

But this situation involves more than questionable use of public money. It also involves incompetent tinkering with the health of from 1,400 to 3,600 persons, and a high-pressuring of Government employees by methods not far short of outright intimidation.

The Group Health Association, composed of Government employees in Washington, has been serving as a guinea pig for those members of the Administration who have been behind the so-called National Health Program and the Wagner Health Act. Many of them favor compulsory health insurance, and for awhile their guinea pig was preciously close to being it. But now, after two years, it is not doing so well. It has had to receive monetary transfusions from both the Government and a foundation in order to stay alive. It may not live much longer.

I assumed the medical directorship of this undertaking with the

understanding that it would be a cooperative venture independent of the Government. Instead of a private organization, I found what was, in effect, an adjunct of the Home Owners Loan Corporation, a Federal agency.

I resigned because lay control invaded the field of medical direction and I could no longer tolerate the irregular way G.H.A. was being handled.

Shortly before my retirement as chief of the Veterans Bureau tuberculosis hospitals in 1937, I was approached by C. D. Otterson, personnel supervisor of the HOLC. He asked whether I would consider an affiliation with a health association to be organized among the Washington employees of that agency.

I understood that the idea originated with R. R. Zimmerman, HOLC's director of personnel. The groundwork for the project was said to have been laid by R. V. Rickord of the Twentieth Century Fund. These plans had attracted the interest of HOLC Chairman Fahey and his assistant, Ormond A. Loomis. (Mr. Fahey is now head of the Filene foundation also.)

Messrs. Loomis and Zimmerman were in constant communication with the Social Security Board. The general impression was that the White House and Miss Josephine Roche were interested in the project. Subsequent events confirmed that impression.

After several conferences with HOLC officials, I accepted their offer to become medical director of the Group Health Association. My new duties entailed organization of the staff, both lay and professional, and securing necessary equipment for the contemplated clinic.

For the medical staff I applied to numerous doctors of my acquaintance and to medical exchanges. A number of high class men seemed willing to accept positions with Group Health. They visited Washington and went over the situation, whereupon most of them declined my offers on the ground that they did not believe the organization could be an economic success. I do not recall that any of these prospects said that they had been approached by the A.M.A. or its representatives.

W. F. Penniman, an assistant to the general manager of HOLC, be-

When Justice James M. Proctor punctured the Administration's anti-trust case against medicine in his now-famous decision, he also pierced the heart of one of the Government's most pampered "babies": the Group Health Association in Washington. His verdict did not discuss the possible illegitimacy of the offspring. But it did accuse the zealous parents of maligning doctors who had acted entirely in the best interests of the case. Whether the political parents of the G.H.A. will be able to revive their infant remains to be seen. Dr. Henry Rolf Brown (see cut), once in charge of the G.H.A., considers it thoroughly unhealthy, the result of an unnatural birth. His expose of the scandal behind it shows to what lengths the forces for state medicine will go in order to attain their objectives. It's a story that is guaranteed to open your eyes—a story you can't afford to forget.

came the first G.H.A. president. R. T. Berry, another member of HOLC's higher bureaucracy, became secretary of the board of trustees. And while Mr. Zimmerman was not a trustee, he and Mr. Loomis were the moving spirits in the organization. Any policy they agreed upon was certain of adoption by the board, which seemed to be mere putty in their hands.

Publicity and promotion of the enterprise were handled by the HOLC's publicity man, Howard Acton, and by his assistant, Mr. Vickery. Both devoted considerable time—their own and the Government's—to this work. The membership campaign was in charge of Mr. Penniman.

Even after an intensive drive, it was difficult to get employees to sign up voluntarily. Mr. Penniman advised his solicitors almost daily not to be coercive among HOLC employees. Although they were to say that membership was purely voluntary, the solicitors were to make it understood that it was highly desirable that they join up. Many employees did so because they felt that if they did not they would lose their jobs. The final drive resulted in about 70 per cent of them becoming members. Monthly dues at that time were $2.20 for individual and $3.30 for family memberships, regardless of the number of dependents.

This supposedly cooperative, self-supporting organization had the backing of Federal funds. A $40,000 "loan" from the HOLC financed its beginnings.

And that was not all. Group Health was given the privilege of the Government discount, when making purchases! Buying was done through the HOLC's purchasing division! Telegrams, clerk hire, and long-distance telephone items were charged to the HOLC! Installation of x-ray apparatus, reconstruction, and repair work were performed by HOLC electricians and carpenters on Government time and using Government materials! All the initial printed forms used by Group Health—about $600 worth—were done by the HOLC! Some Group Health correspondence even went through the mail under Government frank!

During the time I was at Group Health, office equipment, too, came from the HOLC. Anyone who has been in Government service will realize the irregularity of this procedure.

Yet even with this clandestine

Rehabilitation of the VAGINAL MUCOSA

IN THE TREATMENT of vaginal leukorrhea, Floraquin helps to rapidly re-establish the normal flora. It acts not only by destroying the offending organisms, but encourages the growth of the normal flora by replenishing depleted mucosal glycogen and readjusting vaginal acidity to a normal pH.

A COMPLETE RESTORATIVE TREATMENT FOR LEUKORRHEA

IN THE OFFICE—Floraquin Powder, ⅓ to ⅔ drams applied by insufflation at weekly or bi-weekly intervals, following cleansing of the vagina, supplemented by—

HOME ROUTINE—Floraquin Tablets inserted by the patient, night and morning. Acid douches (vinegar solution) "P.R.N."

Both Floraquin Powder and Floraquin Tablets contain the germicide and protozoacide, Diodoquin (5-7-diiodo-8-hydroxy quinoline) together with specially prepared anhydrous dextrose and lactose, adjusted by acidulation with boric acid to a hydrogen ion concentration which maintains a normal pH of 4.0 to 4.4 when mixed with the vaginal secretions.

HOW SUPPLIED

FLORAQUIN POWDER, bottles of 1-oz. and 8-oz.

FLORAQUIN TABLETS, boxes of 12 and 24 tablets.

G. D. Searle & Co.

ETHICAL PHARMACEUTICALS SINCE 1888

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assistance, Group Health has not paid its way.

Early in my service with the G.H.A., I suggested that necessary arrangements should be made for the use of local hospitals. I discussed this matter with the superintendent of Emergency Hospital, who asked me to submit a letter requesting hospital facilities, which he would take up with his board of trustees. I reported to Messrs. Zimmerman and Penniman, who advised me to drop the matter, saying that they would undertake these negotiations themselves. After these laymen entered the situation, the hospitals denied admission to our surgeon and physicians. They said they did not regard our surgeon as fully qualified.

At no time did the local medical association bring pressure to bear upon me. I was in contact with many District of Columbia physicians. None of them ever suggested that I resign, but some did try to convince me of the economic instability of the enterprise.

I had realized this from the beginning, and had been hopeful of convincing members of the Group Health board to effect a sounder basis of operation. But to no avail.

When I began Group Health duties, I had complete charge of the medical department. Business and financial matters were in the hands of the secretary, Mr. Berry, in cooperation with the medical director. But gradually Mr. Berry and the medical director were shorn of all authority and became rubber-stamps under the direction of lay officials. The latter made all rules and fixed all policies. Staff doctors were merely hired hands.

Early in the game, Drs. Allan E. Lee and Stephen Hulburt resigned. It was given out at the time that they quit because of medical association pressure, but I know to the contrary. These physicians resigned because they were not permitted to treat their own private patients and because by that time they did not believe that Group Health would succeed.

It was physically impossible for the staff doctors to give time enough to make careful diagnoses or to give proper medical service. Each of them had between forty and sixty patients a day. Group Health clients had no choice; physicians and specialists were arbitrarily assigned to them. Patients were visited at their homes by clinic doctors, all of whom were required to be on call at night after long days in the clinic.

Dr. Richard H. Price resigned from the organization because of this inadequate service, but he returned when promised an increase in salary and more assistance. However, the promise of a larger staff has not been fulfilled because of dwindling membership and funds. When I left the organization, Group Health had about 3,600 members. Today it has between

"THAT'S THE KIND OF A GUY MY DOCTOR IS!"

1. I used to think doctors were a pretty hard-hearted lot. But, right now, I'm here to say *my* doctor is just about the kindliest man I know.

2. Last week when he said "No More Caffein," I was fit to be tied. Cutting out coffee seemed like cutting out about half the fun of life.

3. But, in the next breath, he switched me over to the doggondest, most delicious coffee I ever tasted . . . Sanka Coffee. With the first cup, I said to myself, "My doctor's not only a swell fellow . . . but a connoisseur of good coffee!"

4. It's a great thing to know about Sanka Coffee when you must tell patients to give up caffein. Since 97% of the caffein is removed from Sanka, they can cut out caffein and still enjoy *all* of coffee's flavor, warmth, and satisfaction.

NOTE TO DOCTORS:

We'd like very much to have you try Sanka Coffee in your own home. Mail the coupon and get your free quarter-pound of Sanka...without obligation. Sanka Coffee has been accepted by the Council on Foods of the American Medical Association with the statement: "Sanka Coffee is free from caffein effect and can be used when other coffee has been forbidden." Now available in both "drip" and "regular" grinds. A General Foods Product.

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REAL COFFEE

. . . 97% CAFFEIN-FREE

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GENERAL FOODS, Battle Creek, Mich.

Please send me, free and without obligation, a one-quarter-pound can of Sanka Coffee.

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Offer expires June 30, 1940—good only in the U. S. A.

1,200 and 1,400. Dues have been increased several times. Group Health is running further and further into the red, and its demise may not be long delayed.

One of its supporters, T. Swann Harding, has already pronounced its obituary and cause of death. Writing in the July 3 issue of The Washington Post, he said:

"If the Group Health Association fails, we shall have only ourselves to blame. The medical societies will not have licked us. We shall have licked ourselves. We shall have proved too reactionary and too stupid to have made full use of our medical opportunities."

This "noble experiment" in Washington was used as a stepping stone to regimented medicine. It had the benefit of much irregularly diverted Government property and a Government "loan"—all at the expense of the American taxpayer. Even then it operated in the red.

Out of it came Assistant Attorney General Thurman Arnold's weird anti-trust suit against the American Medical Association. Fostered by supporters of the National Health Program and the Wagner Health Bill, its record convicts both the program and the bill of impracticability.

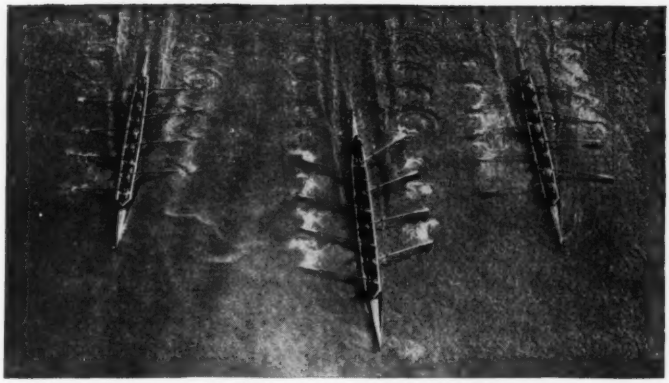
Air corps needs new medical officers

Expansion program promises opportunity for army reservists

The Nation's huge program of air corps expansion, now under way, will require a sharp increase in medical personnel, according to Lieut. Col. C. L. Beaven, chief of the air corps medical section. Doctors holding commissions in the army reserve corps will be called upon to fill the need.

In an interview with MEDICAL ECONOMICS, Col. Beaven said that 117 physicians thus qualified will be given commissions in the regular army during the present fiscal year. They will be appointed as first lieutenants or captains, with salaries beginning at $2,000 and $2,400 a year, respectively.

In addition to appointments in the regular army, funds have been made available by Congress this year to provide special training for 192 medical corps reservists who will be appointed to active duty for a period of one year. Salary, allowances, and privileges in this branch will be identical with those



Rhythm

Reestablishment of natural peristaltic rhythm in cases of habitual constipation may be accomplished with Saráka*. It provides a bland, easily-gliding *bulk*, lacking in the average daily diet. Saráka also gives rhythmic *motility* to the flabby intestinal musculature.

Saráka's bulk forms an integral part of the intestinal contents, softening and smoothing the fecal mass. It causes no griping, digestive disturbances, or annoying leakage.

SARÁKA

is not habit-forming. To pure bassorit granules (derived from an East Indian tree sap) a specially-prepared frangula is added. These give smooth, lubricated

BULK PLUS MOTILITY

Try Saráka clinically in order to convince yourself of its safety and efficacy. Simply fill in and mail the coupon for your free trial supply.

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ANNOUNCING

THE Mulford Biological Laboratories of Sharp & Dohme take pleasure in announcing 'Lyovac' Biologicals, which bring to the physician, and ultimately to the patient, the original therapeutic value possessed by freshly prepared substances at the time of highest potency.

Freezing at sub-zero temperature with rapid dehydration under high vacuum, and maintenance of the vacuum in the finished package, are striking features of this new process.

Biologically active substances, when lyophilized, appear as porous solids, redissolving with remarkable ease and completeness. The lyophile process maintains unaltered the physical structure and colloidal properties of the original material, and permits the carryover of labile therapeutic agents from one season to another with little or no loss of therapeutic efficiency. Restoration to the original liquid state is simply carried out merely by the addition of sterile distilled water supplied with each market package.

of the regular army except that assignments will be temporary, not permanent.

Col. Beaven stated his belief that military service today is more attractive than ever to young physicians seeking a practice foothold. Most applications for admission to the medical reserve, the War Department finds, come from young men who see in it a preliminary step to permanent army berths.

The following requisites now exist for appointment to the medical corps reserve:

1. Possession of the degree of doctor of medicine from a recognized school of medicine.

2. Possession of a license to practice in a State, Territory, or the District of Columbia. (Waiver of license to practice will be made in the cases of diplomates of the National Board of Medical Examiners.)

3. Actual engagement in the ethical practice of medicine.

4. Conformity with age limit. (For original appointment, applicant must not be more than 35 years of age on date of appointment.)

5. Good physical condition (in accordance with the provisions of Army Regulations 40-105).

The air corps expansion program will be spread over a ten-year period, and will call for annual increases in the air corps medical section. The army reckons on the appointment of six M.D.'s per 1,000 commissioned personnel.

Answers to quiz
on page 43

1D 2A 3C 4E 5E 6B 7E

YOUR REASONS ARE GOOD, DOCTOR

Why should you use Agarol when the measure you now use seems satisfactory?

... Archimatthaeus was satisfied with euphorbia and barley boiled in water for the treatment of constipation. Magister Ferrarius found mirobolanum good.

But times have changed. Experience has wrought the change. And the change came from dissatisfaction, ever in search for the better, the more effective, the more satisfying.

Many physicians have found the answer to their quest in Agarol. This good mineral oil and agar emulsion with phenolphthalein softens the intestinal contents, lubricates the channel of their passage and gently stimulates peristaltic activity. It combines effectiveness with exceptional palatability.

Why should you try Agarol? Because it satisfies the demands of modern medicine for a bowel evacuant and a therapeutic measure for the treatment of habitual constipation. Send for a trial supply. See how Agarol compares.

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Agarol is supplied in bottles of 6, 10 and 16 ounces. Adult dose, 1 tablespoonful. Children, 2 teaspoonfuls.

Why is Refined Karo Hypo-allergenic in *Infant* Nutrition?

INFANT FEEDING PRACTICE POINTERS

Answers to Physicians' Questions

1. **Q.** What allergic diseases occur in infants?
   A. *Gastro-intestinal allergy. Pylorospasm. Eczema. Bronchial asthma.*
2. **Q.** What sugars may be allergenic?
   A. *Honey, cane sugar, beet sugar, barley sugar.*
3. **Q.** What makes Karo safe bacteriologically?
   A. *Karo is heated to 165° F. and poured into pre-heated cans and vapor vacuum-sealed for bacterial safety.*
4. **Q.** What is a goat's milk formula for the newborn?
   A. *Evaporated goat's milk, 6 ozs. Boiled water, 12 ozs. Karo Syrup, 2 tablespoons.*
5. **Q.** What is a vegetable milk formula for the newborn?
   A. *Powdered vegetable milk, 6 tablespoons. Boiled water, 20 ozs. Karo Syrup, 2 tblsps.*

The medical literature to date reveals no incident in which Karo Syrup has been found to be allergenic in infant feeding. Hence Karo may be safely used in the formulas of allergic infants. Whether evaporated, goat's or vegetable milk is used, Karo is a universal milk modifier.

Karo is produced by the conversion of corn starch into mixed sugars at a high temperature. The large amount of dextrin and the small amounts of maltose, dextrose and invert sugar cause no sensitization. The traces of inorganic constituents are devoid of such action; and the traces of protein produce no allergic reactions even in corn-sensitive infants.

"Infants Thrive ON Karo Formulas"

Infant feeding practice is primarily the concern of the physician; therefore, Karo for infant feeding is advertised to the Medical Profession exclusively. For further information, write Corn Products Sales Company, Dept. E-9, 17 Battery Place, New York City, N. Y.

Investors' Clinic

If peace prevails . . .
"Municipal revenue" issues
Are Government bonds too high?
Profits in the powder keg
The utilities stage a come-back
More power to electrical equipment
Clean bills for A.T.&T.
Why copper mining is booming

The stage is now set for a market advance, barring one deterrent: fear of war. Given a fifty-fifty prospect of peace, business men will feel like putting their money to work in industry, and stock prices will rise. Given only a forty-sixty chance, or less, both business men and security markets will be jittery.

This point has been proved conclusively during the first seven months of this year. So follow European developments closely when planning new purchases of securities. Then, if you decide to buy, do so conservatively—preferably for cash. Conditions are still uncertain abroad. Hence the wisdom of not biting off more than you can chew.

☆

A new type of municipal obligation has been introduced to investors in recent months. It's called the "municipal revenue bond." More than a billion dollars' worth of such bonds have already been sold.

Municipal revenue bonds pay a higher interest rate than ordinary city obligations. But there's a hitch: They're not guaranteed by the city issuing them. Instead, they are secured only by the properties against which they were issued, such as a municipally owned street railway or a municipal power plant. Now, if the railway or power plant fails to earn money to pay interest, the bondholders are powerless to demand that the city make good on the payments. The city's own credit is not even involved.

So I'd think twice before buying any municipal revenue bonds. Better to accept a lower interest return on bonds fully guaranteed by the resources and taxing power of the municipalities issuing them.

☆

Are U.S. Government bonds too high?

They've risen sharply since the first of the year. What's more, they yield so small an interest return that many private investors find them unprepossessing—except, that is, for people with huge fortunes who are willing to pay a high price for tax exemption.

This gives rise to the suspicion, voiced in some quarters, that they're due for a Humpty-Dumpty tumble. But against that suspicion, weigh these two factors:

The Government today controls the levers that derrick bond prices upward or downward. With more

Treasury financing planned, it's hardly likely that prices will be dumped into the cellar.

Second, the Nation's banks are heavily loaded with Government bonds. A break in prices would force hundreds of banks against the wall. Certainly, the Government doesn't want that.

I'd be in no hurry to sell holdings in Federal bonds.

☆

Profits of the American powder manufacturing industry are improving. That fact may seem like a sure tip that war is coming. But powder today has become an important peace-time as well as war-time industry. Consider its many everyday uses in blasting for mining and in increased construction work. Also, in hunting and other popular sports.

Of course if war *should* break out, this industry, unlike most, would be quick to benefit and its present profits would be multiplied.

An investment in powder company shares holds attraction, therefore, war or no war.

☆

"Over $500,000,000 in New Public Utility Bonds To Be Sold Publicly Before Labor Day."

Thus a recent headline. Behind it, three points of significance to investors:

First, it shows that utilities are more confident about their future. Else they would not be prepared to spend such big sums.

Second, it indicates that large investors, such as insurance companies, again believe it safe to put new money into the industry.

Third, it reflects the conviction of large investors, utility people and bankers alike, that the Government no longer intends to spend billions of dollars on power projects that will compete with privately owned utilities.

On the strength of these considerations, the new public utility bonds seem safe enough as investments.

I'd stick to first mortgage bonds, however. Also, to those companies with properties in growing manufacturing regions. They stand the best chance of meeting interest payments. Those whose properties are scattered from coast to coast are least desirable. Reason being that over-extended power systems are still in disfavor with the Government, which is breaking up the so-called public utility holding companies. [*Turn the page*]

Markedly Effective
in treatment of SYCOSIS VULGARIS

DR. S. M. PECK[1] has reported Ointment Quinolor Compound to be markedly effective in the treatment of *sycosis vulgaris*. Commenting on the reactions of many of the patients who had failed to respond to other methods of prolonged treatment, Peck states: "Not the least gratifying is the enthusiasm of the patients, many of whom had made up their minds that they were afflicted with an incurable disease."

Composition . . . Ointment Quinolor* Compound contains 10 per cent benzoyl peroxide and 0.5 per cent Quinolor (Compound Chlor Hydroxy Quinolin) in a base consisting of equal parts of white petrolatum and deodorized, anhydrous lanolin. Benzoyl peroxide was chosen as an ingredient because comparative tests made at the University of California[2] indicated that it possesses tissue-repair-promoting qualities. It is also an aid in relieving pain and itching.

Indications . . . Ointment Quinolor Compound may be used especially for the treatment of sycosis vulgaris or sycosis barbae, and of tinea sycosis. Applied to superficial wounds, it acts as a protective antiseptic dressing and may be used under circumstances in which liquid antiseptic dressings cannot be repeated at short intervals. Its antiseptic action continues over a considerable period of time.

Send for a Trial Sample

Ointment Quinolor Compound is supplied in 1-ounce tubes, 50-gram and 1-lb. jars. We shall be pleased to send you a generous trial tube and literature without cost. Use the coupon below.

* Quinolor is a trade-mark of E. R. Squibb & Sons.

[1] Peck, Samuel M.: *Arch. Dermatol. & Syph.* 29:456-57, 1934.

[2] Lyon, R. A., and Reynolds, T. E.: *Proc. Soc. Exper. Biol. & Med.*, 27:122, 1929.

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Manufacturing Chemists to the Medical Profession since 1858

E. R. SQUIBB & SONS, ME9
Professional Service Department,
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Attached hereto is my professional card or letterhead. Please send me, without obligation, literature and sample of Ointment Quinolor Compound.

Name .....

Street .....

City ..... *State* .....

Electric power production is up to near-record levels. But if you're looking for a chance to cash in on this expansion, don't stop with public utility bonds. An even better place to invest your money, I think, is in the electrical equipment industry. Here are the reasons why:

The power companies need new turbines, generators, and other heavy equipment. Consequently, a good part of prospective new earnings of the utility industry will be syphoned off to the electrical equipment manufacturers.

What's more, the equipment companies in recent years have greatly enlarged their line of products. The new additions include air-conditioning equipment, radios, and many electrical household conveniences such as toasters, percolators, and electric irons. If consumers see their way clear to buy more current, it is logical to expect that manufacturers of electrical equipment will participate in this improved business.

Finally, the makers of electrical appliances and equipment are not under the strict State and Federal regulation that the utilities have to contend with. Relatively speaking, their profit operations are uninhibited.

☆

Highly favorable to shareholders of that self-contained industry, the American Telephone & Telegraph Company, were two recent judicial verdicts. Both in Wisconsin and in Oklahoma, high courts ruled that the company's rates are fair. In fact, one court approved an advance, over stubborn State opposition!

These two victories will help A. T. & T. in rate cases pending in

other States. And it will discourage still other commissions which have been contemplating action to force reductions.

A. T. & T.'s record through the past ten years of business depression has been notable. Service has been kept up to a standard unapproached in any other part of the world. The company itself has played fair with shareholders even though, in some years, it has had to dig deeply into its surplus to pay dividends.

Meanwhile, through an enlightened public relations policy, it has convinced both the public and lawmakers that it is one monopoly which is serving a genuine public interest and should not be destroyed.

The company's shares, over a long period, have proved to be one of the soundest investments obtainable.

☆

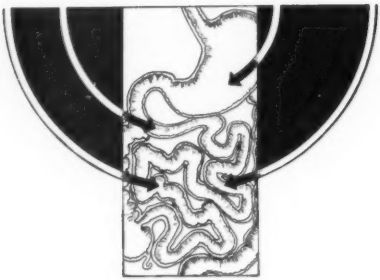
Ever stop to think of the many uses to which copper is put today? It is called into heavy use by manufacturers of electrical appliances, power lines, wire, telephone and telegraph instruments, shingles, and a wide variety of other materials going into road, bridge, railway, residential, and public works construction.

All of these industries have done better this Summer than they did a year ago. And their improvement has been reflected in the recent upturn in the copper mining business.

A moderate investment in shares of leading copper companies is worth considering. Particularly since this industry would benefit quickly from increased manufacture of armaments.

—FRANK H. McCONNELL

EXTENDED ANTACID ACTION



The low solubility of magnesium hydroxide extends its antacid action into the intestines with little interference with the stomach. Thus, Phillips' Milk of Magnesia exerts an effective antacid action where it is most needed, yet largely avoids the harmful hypersecretory responses which follow administration of ordinary "alkalinizing" agents.

Gentle yet thorough laxative action is brought about by conversion of magnesium hydroxide into magnesium bicarbonate in the intestines.

Phillips' Milk of Magnesia, the original product, has proved its dependability in exerting both effects during sixty years of constant use.

For Convenience—

Phillips' Milk of Magnesia Tablets—each tablet is equivalent to one teaspoonful of Phillips' Milk of Magnesia (liquid).

Dosage:

As an antacid: 2 to 4 teaspoonfuls (2 to 4 tablets).

As a gentle laxative: 4 to 8 teaspoonfuls (4 or more tablets).

PHILLIPS'
Milk of Magnesia

Prepared only by THE CHAS. H. PHILLIPS CHEMICAL CO. New York, N.Y.

Letters to a doctor's secretary

4. WORKING EFFICIENTLY

[This is the fourth in a series of revealing letters written by a doctor's assistant to the girl who took her place when she left to be married. The series constitutes a valuable training course in professional office procedure.—THE EDITORS]

Dear Mary:

I asked you to write me always with perfect frankness. I'm glad you took me at my word.

Your last letter sounds as though you were discouraged—violently so. I like your violence. It can work miracles when properly directed.

You say you get along well in the mornings, that you have the clerical work well in hand; but, oh, the afternoons! When you have to help the doctor in the examining room and act as nurse and secretary at the same time, it just about drives you crazy. You say you simply can't be in three places at once; that in the daily schedule I gave you I allotted no time for making dressings, checking laundry, sterilizing, and a dozen other things you must do behind the scenes.

Your complaint is justified. But I hasten to assure you that the case is far from hopeless.

The things you mention constitute the mechanical end of your work. They require, in the main, only manual dexterity. As soon as correct habit channels are formed, you'll be able to standardize them so that they'll practically perform themselves.

But correct habit channels—there's the rub. To form them at the start takes real concentration.

In this connection, get a copy of the volume called, "Learning How to Study and Work Effectively," by Wm. F. Book, head of the department of psychology and philosophy at Indiana University. It's published by Ginn & Co. and is thoroughly authentic from the point of view of medical psychology. It's practical, too, as it represents not theory, but the results of exhaustive, down-to-earth research. If you study it carefully, adapting it to your personal circumstances, you will have built a foundation on solid rock. The chapter on "Job Analysis of One's Tasks," is particularly well geared to your present difficulties.

Returning to those difficulties now, we must first break down the

typical afternoon's "frenzied hodge-podge" into a list of the separate things that go to make it up. In addition to the secretarial and reception-room duties previously discussed, there will be these:

1. Preparing women patients for examination, and assisting the doctor during examination.

2. Cleaning up the examining room after each patient, and cleaning up the laboratory after the doctor has finished working there.

3. Sterilizing gloves, instruments, and dressings.

4. Making dressings, swabs, and cotton pledgets.

5. Checking and ordering supplies and laundry.

That's quite a list, considering the fact that you're supposed to be in the reception room most of the time to do your job of receiving, and that the telephone usually rings all afternoon. But it's really not so bad as it sounds. It means that you have to increase your tempo, but it need not spoil the rhythm or the music. The whole thing is really a matter of harmony, i.e., "a just adaptation of parts to each other, giving a pleasing whole." Note especially the word "just." If you make up your mind not to give a second more to any task than it justly deserves, things will seldom pile up on you. I don't need to add that this harmony must exist in your mind before it can exist in your actions.

I think perhaps you've been trying too hard, rushing too much, and getting a little muddled. William James blamed the frequent breakdowns of American business men and other workers, not on an excessive amount of work nor on the nature of the work, but on "those absurd feelings of hurry and of having no time, that breathlessness and tension, that anxiety of feature, and that solicitude for results, that lack of inner harmony and ease." Said he: "It is your relaxed and easy worker, who is in no hurry, who is your efficient worker." And who are we to dispute William James?

But let's get down to cases and examine in order the five duties listed above.

Office hours have begun. A long list of appointments stretches ahead of you. Doctor Barrie has taken the history of Mrs. Smith, a new patient, and has rung for you to get her ready for a complete examination.

You usher her immediately into the examining room. You don't stop to chat with her; but your manner is pleasant and interested, with no appearance of hurry. You give her the necessary directions in a firm, clear voice, with not a syllable wasted, so she'll know exactly what to do. Have a regular formula so that even the slight effort of thinking about what to say is unnecessary. Such as:

"Please remove all your clothes, except your slip and shoes and

stockings. I'll be right back."

Then leave the room.

This routine is so old a story to office nurses that some form the lamentable habit of giving directions hurriedly and vaguely, taking it for granted that the patient will know what to do. Yet if you've ever been a patient yourself, you know how unsatisfactory and embarrassing this can be.

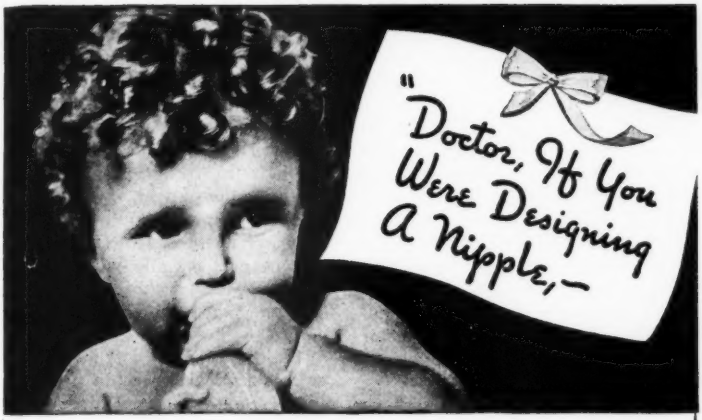
Naturally, the nurse is annoyed when she comes back in a few minutes and finds the poor woman sitting on the edge of a chair, flushed and nervous, with most of her clothes still on. But it isn't entirely the patient's fault.

So be sure to tell the patient exactly what to do. And don't forget the "I'll be right back." It speeds her up and reassures her at the same time.

When you leave her, you slip back into the reception room, greet anyone who has arrived in your absence, and usher the next patient into the consulting room where the doctor can keep busy until you call him.

You then return to the examining room and find Mrs. Smith awaiting you in the correct state of semi-nudity. You assist her into position on the examining table and drape her with a fresh white sheet. From a drawer in the examining table you take all necessary instruments and lay them in a row on the side table. You buzz for the doctor and stand by while he proceeds with the examination.

In the pocket of your uniform always carry a small pad of paper and a pencil. For Dr. Barrie likes to dictate his findings as he exam-



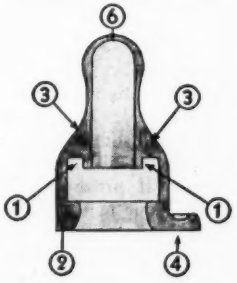
WOULD YOU DO IT THIS WAY?"

1 Special Davol Flange, insuring air-tight connection with neck of bottle.

2 3/16-inch wall at base, forming a sturdy rubber ring which holds the nipple firmly on the bottle.

3 Firm, reinforced shoulders, simulating the firm areola of the breast.

4 Pull-tab; hygienic, eliminates the need of handling the sterilized nipple; convenient in attaching nipple to bottle.



5 Short tip; more naturally adapted to the size and shape of the infant mouth than the long, large tips.

6 3-hole feature; minimizes the chances of collapse and obstruction, thus permitting a steady flow of food.

DAVOL

"Anti-Colic"

T. M. Reg. U.S. Pat. Off.

BRAND NIPPLES

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Providence, Rhode Island

Please send me a complimentary copy of "Illustrating the Breast, Before, During and After Lactation", containing 18 medical and anatomical drawings in color by M. McLatchie and H. F. Aitken.

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ines (with the obvious exception of anything that might alarm the patient).

If, during the examination, someone enters the reception room or the telephone rings, step out quickly and attend to it, leaving the door very slightly ajar behind you. The idea is that the doctor should never be left alone with a disrobed patient. This is merely a matter of good form. The more refined type of woman patient prefers it; and with the other type it is occasionally a real protection to the doctor. At all events, get back to him as soon as possible.

As he finishes with his gloves and instruments, he lays them on a paper towel which you have placed on the instrument tray. The examination over, he returns to the consulting room.

Meanwhile you help Mrs. Smith from the table, telling her (again, clearly and distinctly): "You may dress now. Dr. Barrie will return and talk to you in a few minutes. Just wait for him here."

This will prevent her popping her head out of the door or wandering vaguely about after she is dressed. And it is clearly better form for Dr. Barrie to talk over his findings with her after she is dressed than while she is still on the table.

Your next step is to pick up the instruments and gloves in the paper towel on which they were laid, gather up the sheets which covered the examining table and the patient, then walk (don't run) to the surgery. Put the sheets in the laundry closet; rinse off the gloves and instruments and place them in the sterilizer (which is kept boiling all afternoon); take a short turn through the reception room; and return to the patient.

As she is putting on her hat, you take a clean sheet from the cabinet and cover the table with it. This has a good psychological effect. You then buzz for Dr. Barrie who comes to finish the interview.

If the patient he left in the consulting room is ready to be examined, you take her to the second examining room, usher the next patient from the reception room into the private office, and begin the cycle all over again.

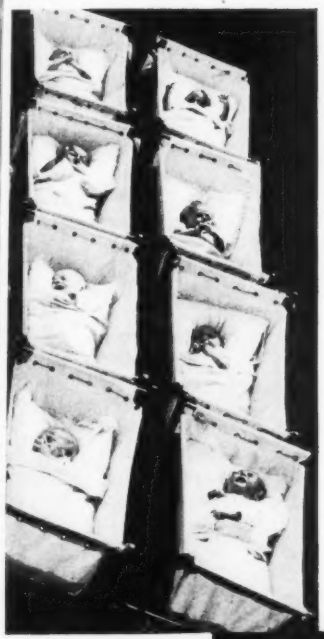
Next time you return from the surgery bring with you the instruments that have just been sterilized and put them away in the examining table drawer. Rubber gloves have to dry thoroughly and be powdered, so don't try to use them the same day they have been boiled. Keep a plentiful supply on hand.

Can you sense the rhythm in this procedure? If you like music it's fun to think of the afternoon as a symphony. Don't get tense. Breathe deeply. Try to make all your movements graceful and exact, never jerky or abrupt.

Dr. Carl does most of the laboratory work; and I'll admit the

Accidental Discovery

Gelatinized Milk DECREASES INCIDENCE OF UPPER RESPIRATORY INFECTIONS IN INFANTS



Many a useful discovery has resulted from a chance finding by a keen observer.

Two years ago a group of university workers fed milk containing 1 and 2% plain, unflavored gelatine to a group of infants. There was a lower incidence of vomiting, diarrhea, and constipation than in control groups. As a corollary, they noticed that those receiving the gelatine formula suffered fewer upper respiratory infections. This was interesting enough to demand further study. The work* was recently repeated in two different clinics and the results substantiated. Knox Gelatine (U.S.P.) was used. It is 100% pure U.S.P. Gelatine—85% protein—in an easily digestible form—contains no sugar and should not be confused with factory-flavored, sugar-laden dessert powders.

*Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk. C. Loring Joslin, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

Write Dept. 448

KNOX GELATINE LABORATORIES

JOHNSTOWN NEW YORK

Please send reprint of Joslin study.

*Name*_____

*Street*_____

*City*_____ *State*_____

place looks as though a cyclone had struck it when he gets through. But any girl who's ever washed the dinner dishes at home will find it easy to clean up after him in less than five minutes.

Two or three times during the afternoon look into the laboratory and do whatever is necessary. Repeat this again just before you go home.

Some day when you're not very busy or when Dr. Barrie is away, ask Dr. Carl to teach you how to do bloods and urinalyses. You'll find it so fascinating that you'll never again mind washing a test-tube. It will make you more valuable, too.

I've said that you must spend as much of the afternoon as possible in the reception room. And that's so. You will really have more time for it than you think, because a number of the patients are men. Many spend their whole appointment in the consulting room, so that your presence is not needed.

It is the custom in a number of doctors' offices to have, not a reception room, but merely a waiting room, with no desk and no receptionist in evidence. I believe this is a grave mistake. If a doctor has a secretary, her desk should be—as yours is—in the direct line of vision of anyone opening the door. Her welcoming, questioning face should be the first thing the patient's eye lights upon. Even if you aren't at your desk just then, he'll see it there, with your work laid out upon it, and will know that you'll be back in a minute.

On your desk, and at every telephone extension in the office, keep a pad and pencil—tied down if necessary. If Dr. Barrie is with a patient, record all telephone calls that aren't urgent. Promise that you'll call back a little later when the doctor is free to talk. This adds greatly to the general smoothness of office hours.

As for making and sterilizing dressings and swabs, I found it best to devote two hours a week on a certain *morning* to this task. By so doing you can easily keep an abundant reserve supply.

This duty was so very dull that it always bored me frightfully until I hit upon the plan of trying to break my own record. I timed myself to see how many I could make perfectly in a minute, and whether I could make more by working straight through or by resting one minute out of every ten. I found the latter method much the faster.

With our up-to-date sterilizer it takes only a little while to sterilize a week's supply. But be sure to get it done by eleven o'clock so the steamy smell will be completely gone before office hours.

Twice a week the laundry is picked

Salt brings water to quicker boil

If you use a small electric sterilizer for 2 cc. and 10 cc. syringes, why not borrow a trick from your wife? Put a pinch of table salt in the water. It induces a quicker and more vigorous boiling. But be sure there is enough water in the holder. Otherwise, bubbling may become violent enough to break the syringes.—SIDNEY AIKEN, M.D., Manchester, Conn.

up and returned. Twice a week, first thing in the *morning*, count and list the outgoing and check the returning. Each of these operations takes only five minutes if you'll concentrate. Putting the laundry away may take another five. There's thirty minutes out of your week. Why worry about it?

As for checking and ordering supplies, I repeat: System, system, system! Keep a little notebook with a pencil attached to it in the surgical-supply cupboard, and another one in the stationery- and clerical-supply closet. Everything should be clearly labeled. When anything is getting low, jot it down in the book. Keep on the first page the name and telephone number of the firms with which you deal. A brief telephone call or a postal card will keep you from running short.

In this connection, let me say that shopping about too extensively for low prices is not good practice. Deal only with reputable and well established firms. Get to know the salespeople personally; establish friendly relations; and "grapple them to your soul with hoops of steel." If you do, they'll give you personal and efficient service. They'll make prompt deliveries on a moment's notice. They'll send up anything on approval. They'll allow you to return for credit anything that doesn't satisfy you. And if they don't have what you want, they'll order it for you. Dealing with such people will save many hours of time and much money in the long run.

I hope you feel better, Mary, and not worse after this fusillade of advice. I'll write you again soon.

Meanwhile, take for your motto the old jingle,

That man is blest
Who does his best
And leaves the rest—
Don't worry!

Reassuringly yours,
Myrna Chase

Just published

ARTICLES

A CHALLENGE TO MEDICINE. A symposium on sickness insurance by Drs. Haven Emerson, Roger S. Siddall, and Joseph T. Smith. (Atlantic Monthly, August 1939)

GROUP MEDICINE AT WORK, by Frank J. Taylor. The story of California's Ross-Loos Medical Group. (American Mercury, August 1939)

SOCIALIZED MEDICINE, by Maxine Davis. An analysis of health insurance. (Good Housekeeping, August 1939)

MEDICAL ROMANCE IN PHILATELY, by Otho C. Hudson, M.D. A series of five articles. (Stamps, July 15-August 12 issues)

BOOKS

THE RECOLLECTIONS OF A COUNTRY DOCTOR, by James A. Halley. Fifty-three years of practice in retrospect. (Meador, $1.50)

Paying for your children's education

Explanation of several methods by which money may be saved for college expenses—as well as for other future needs

As you hand out cigars after the birth of your first-born, you may find that one of them is accepted by an insurance agent. He has heard about the happy event and has hastened around to sell you an "educational" policy.

This reminder of your new responsibility raises the question: What provision should be made now for those college expenses later?

Of course, your income may be sufficient to pay the college expenses as they occur. Most medical men, however, find the education of their children an expense that must be planned for in advance.

The first step is to estimate the *minimum* expenses of a college education, basing this estimate on the requirements of a low-cost State university or similarly inexpensive college. It is important to keep the cost to a minimum, because the savings plan if followed throughout poor times as well as good necessarily represents a heavy burden. Part of future increases in income or part of legacies or other windfalls may be used to provide some of the educational "frills," but the first plan should include only fundamentals.

Part of this cost may well be made the child's responsibility. Probably the most important advantage of so doing is that an education to which the child has contributed will mean more than one which is a handout.

Demands on children should, however, be limited. For requiring the college student to carry on a job during the school year involves a strain which many educators believe to be too great. Moreover, the job may interfere with extra-curricular activities which are important benefits of the college period. Therefore, if the child is to provide part of the college expenses, he should be encouraged to start long before the funds are needed.

After determining the minimum educational expense and the proportion to be borne by the children, you face the questions: When should the savings program be started? How should the funds be saved?

The doctor with young children, who is still struggling to start his practice, may go through a protracted period of low earnings and heavy expenses. During this period, it does not appear advisable to attempt to save anything for later educational expenses.

An important factor in determining the selection of the best sav-

ings media is the nature of your income. A doctor with an *assured* salaried position may commit himself to the saving of regular sums. However, if his income fluctuates, as is true of most doctors in private practice, it is preferable to start a savings program which may be increased in good times and decreased in poor times.

If an endowment policy is obtained, then carried for only one year (in some companies, two years), and finally discontinued because of inability to pay premiums, nothing is returned to the doctor. Consequently, in view of the uncertainties of medical practice, it is doubtful whether funds for the education of children should be accumulated in this form.

Sometimes, annual-premium retirement annuities are used for educational purposes. The premiums for such policies are accumulated by the company at interest. And because the contracts do not involve insurance protection, the cash value is usually accumulated more rapidly than in endowment policies. However, these policies, too, must be carried for several years before the cash value becomes equal to the premium paid, even without allowance for interest.

This possibility of realizing less than the investment if forced to discontinue the savings program within a few years does act as an incentive, of course, to those who find saving a difficult job. On the other hand, for those to whom saving comes easily and whose only worry is whether they'll have the money to put aside, savings accounts, United States Baby Bonds, and similar methods of saving may be a better choice. Funds accumulated

A PLACE in every PRACTICE

No matter what type of practice you have, you will encounter frequent occasions where the non-narcotic sedative, Pentabromides, will be found valuable.

For example:

Obstetrics—to relieve nervous symptoms during pregnancy.

Neurology—for hysteria, convulsions, epilepsy.

Gynecology—to control nervous symptoms of the menopause and dysmenorrhea.

Pediatrics—to calm the hyperexcitable child.

Internal Medicine—to combat nervousness in hyperthyroidism, peptic ulcer, nervous diarrhea.

Surgery—to allay preoperative and postoperative nervousness.

Nose and Throat—as a postoperative sedative and an aid in relieving sinus headaches.

General Practice—in nervousness, insomnia and other conditions requiring effectiveness and reliability in sedative medication.

PENTABROMIDES

Two pleasant, effective dosage forms:

PENTABROMIDES

An especially palatable syrup, each fluidounce containing sodium bromide, 64 grs.; potassium bromide, 20 grs.; ammonium bromide, 20 grs.; calcium bromide, 12 grs.; lithium bromide, 4 grs.—15 grs. of the combined bromides per fluidram. 16 oz. bottles.

PENTABROMIDES TABLETS Effervescent

Each tablet when dissolved in water represents sodium bromide, 8 grs.; potassium bromide, 2½ grs.; ammonium bromide, 2½ grs.; calcium bromide, 1½ grs.; lithium bromide, ½ gr. Bottles of 25.

THE WM. S. MERRELL COMPANY

Founded 1828 **Cincinnati, U. S. A.**

in these forms will yield a return at least equal to the investment, even if the savings program must be discontinued or suspended. Moreover, savings accounts and Baby Bonds have the advantage of flexibility. The amount saved each year can be temporarily increased or decreased as income fluctuates.

Insurance can, however, be used in the savings program. One method of doing so is suggested by the fact that the family's needs are obviously greater when children are young.

The doctor's ordinary life insurance can be decreased by the time his children enter college. The cash value of the discontinued insurance can then be used for part of the educational expenses.

Another method of saving funds in insurance companies is to leave dividends to accumulate at interest. This procedure has many advantages. No commissions or charges need be paid on the dividends left with the companies in this manner. Moreover, a program of leaving dividends with the companies is flexible. In any year when income is low, the program may be temporarily suspended without involving surrender charges, interest, or other expense.

On dividends left with them, the insurance companies guarantee an interest rate. This rate is 2½ per cent in most of the policies issued at the present time and is guaranteed by the policy provisions; for policies issued in past years, the rate is usually 3 or 3½ per cent. In addition, the accumulated dividend fund is participating; so the interest rate actually paid by the company is sometimes higher than that indicated by the policies. Speaking generally, the use of dividends on insurance policies in this way is one of the most favorable methods by which the physician can accumulate funds.

To summarize, a program of accumulating funds for the education of children should embrace the following:

1. Estimating the *minimum* fund that will be required.

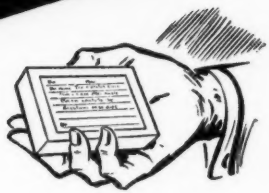
2. Apportioning part of this to the children as their responsibility.

3. Deciding on the extent to which insurance may be decreased as the children complete their educational period (the cash value of the insurance so discontinued being regarded as part of the educational fund).

4. Computing the savings required each year. [*Turn the page*]

IN DIABETES MELLITUS

We invite you to test UVURSIN



UVURSIN is an ethical product worthy of your attention. It is a mild, innocuous oral treatment for diabetes and can be administered alone or as an adjuvant.

We know of no better way to demonstrate the efficacy of UVURSIN than to have you test it and see the improvement in one of your own cases.

Let UVURSIN write its own record in the case history of one patient. Then judge it on results.

Coupon below will bring you a quantity sufficient for a 27-day trial without cost or obligation.

ORAL • INNOCUOUS • EFFICACIOUS

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Please send me 27-day supply of UVURSIN without cost or obligation.

Dr. .....

Street .....

City..... *State*.....

5. Deciding in what form the annual amounts will be set aside (e.g., as dividends deposited with life insurance companies at interest, as savings bank deposits, or as Baby Bonds).

Baby-care booklets win patients' good will

Used by physicians as gifts for new mothers

If you're willing to dig down into your jeans for $2, you can warm the cockles of any new mother's heart by presenting her with a little pink package put out by the J. B. Lippincott Company.

In this package are thirteen captivating booklets which bear the title, "Baby Care." The first is a manual for expectant mothers: the others are a guide to the care of the baby during its first year, one booklet being devoted to each month.

Topics discussed include bathing, feeding, clothing, and general care. The booklet labeled "First Month" gives easy-to-read pointers on such things as bottle feeding, breast feeding, and preparing the formula. Other booklets talk about exercise, inoculations, weight, teething, common illnesses, etc.

"Baby Care" was written by May E. Law, who is both a mother and a graduate in medicine of the University of Glasgow. Throughout the series, the reader is referred to her family physician, the text being limited strictly to those topics which are suitable for lay consumption.

"This book," Mrs. Law says, "is intended to help mothers follow

such orders as the doctor gives. It must not be considered a substitute for the doctor's advice. Seek the services of your doctor early."

This kind of a series should act as a strong stimulus to the mother's desire to learn more about herself and her baby. It should encourage more frequent consultations and make more binding the doctor-patient relationship—with obviously beneficial results.

The "Baby Care" booklets measure 5½" x 7½" and average about sixteen pages each. The pink box containing them is made in the likeness of an attractive book.

They call it relief

[*Continued from page* 34]

quire all those on WPA for eighteen months to leave their projects for a thirty-day "furlough." Within this thirty days, the doctor who wants to get back on WPA must be re-certified.

Many institutions and organizations offering salaried positions, will not employ an ex-relief doctor. His one hope would seem to be to return to private practice.

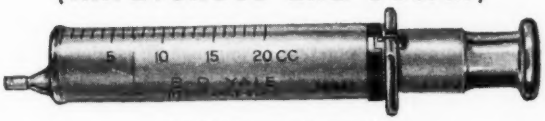
Theoretically, his WPA chiefs encourage this. They advise him that he is expected to "rehabilitate" himself. But they seldom tell him *with what.*

For to become eligible for relief, he had to strip himself of all means. His only resource, except perhaps for a tiny practice on the side, is his relief check. After the necessities of his family and himself are deducted, there's little left.

Another factor that militates against the doctor's getting back into private practice is the not infrequent tendency to shift him from

ANESTHESIA

(Intravenous and Sacral)



B-D Yale Syringe with eccentric tip, especially well adapted to intravenous administration.

INTRAVENOUS ANESTHESIA. The B-D Yale Syringe No. 20YE, 20 cc. capacity, with eccentric tip, and a 20 gauge 1¼", short bevel needle, are standard equipment with many authorities. The syringe is illustrated above.

The needles best suited for intravenous anesthesia are the B-D Yale Rustless Steel No. LNR, or B-D Erusto Stainless Steel Needle No. LNE, 20 gauge 1¼", short bevel. This gauge is large enough to hinder coagulation in the inside of the needle while it rests in the vein during the operation, and the special beveled point also hinders seepage into the tissue after the needle is withdrawn.

SACRAL ANESTHESIA. The B-D Quincke Spinal Needle No. 462LNR, 19 gauge 3½", together with a 10 cc. B-D Luer-Lok Control Syringe, are commonly employed in sacral work. This type of syringe has large, comfortable thumb and finger rings for convenient one-hand control, and also the strong Luer-Lok tip into which the needle locks securely with a half-turn. This prevents it from jumping off at a critical moment.

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

B-D PRODUCTS

Made for the Profession

STANDARD OF THE MEDICAL PROFESSION SINCE 1897

project to project. For much of this, WPA blames cancellation of certifications by home relief bureaus. Whatever the reason, the effect is to make it difficult for the doctor to establish useful contacts which might help him to re-enter private practice.

Many cancellations can be traced to the rule that WPA doctors must not earn more in private practice than the so-called "prevailing wage." The latter varies with locale; in New York City it is about $22 weekly.

WPA doctors are compelled to file quarterly statements of private earnings. They are also investigated twice a year. If it can be shown that their private income equals the "prevailing wage"—out they go. This process is known as "cancellation of certification." Many a doctor thus cast adrift wishes he were back on WPA—and, often he soon is.

Under the New York WPA system, the M.D. turnover is practically nil. The only change recorded during the past year was a decrease of 5 per cent in the roster of doctors on relief.

In many cases, the only way out seems to be that available to single men—a fortunate marriage. That this is widely recognized is shown by the current use among the city's impecunious young medical graduates of the term, "money-honey." It means a pleasant young woman whose father has enough wherewithal to ease a tyro over the rough spots.

It's no wonder that, as a relief official confided:

"Most doctors on WPA would welcome state medicine. And why not? What have they got to lose?"

Location tips

A free service to M.D.'s seeking places in which to practice

An up-to-date list of towns in which physicians have just died is compiled each month by MEDICAL ECONOMICS. A copy of the current list is now available on request.

Shown with the list is the population of each town, the number of physicians there, the specialty (if any) of the deceased, and the hospital facilities available.

The death of a physician (only active, private practitioners are considered) does not, of course, guarantee a vacancy for another doctor. But openings are created in a sufficient number of towns so that

To help wash acids from stiff, aching muscles...*suggest*

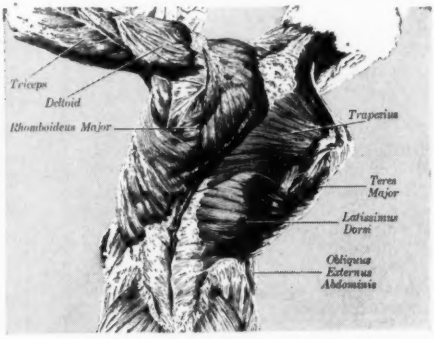
ABSORBINE Jr.

WHEN unaccustomed exercise or over-exertion leaves toxic waste products in the muscles, organic acids contained in these deposits frequently cause muscular aches and stiffness. In clearing up this painful condition, Absorbine Jr. is a helpful suggestion.

Laboratory tests have shown Absorbine Jr.'s effectiveness in stimulating—without stasis—the flow of peripheral blood while accelerating the velocity of blood flow in the deeper vessels of the muscles as well. This action helps flush out the muscles and brings new energy to the affected tissues.

Thus, the application of Absorbine Jr. every 3 or 4 hours expedites removal of toxic wastes and speeds relief from this common cause of muscular distress. Because Absorbine Jr. contains no strong irritants, it occasions no painful burning when your patient pats it on.

A complimentary professional-size bottle of Absorbine Jr. will be sent at your request. Please use your professional letterhead.



Absorbine Jr.

W. F. YOUNG, INC.

207 Lyman St., Springfield, Mass.

they amply merit investigation.

Only those communities are included in the list which have less than 50,000 inhabitants and in which the ratio of physicians to population is reasonably favorable.

Names of some of these towns are submitted by cooperative doctors and laymen. In most cases, however, they are obtained from MEDICAL ECONOMICS' post-office returns (returned copies marked "deceased"). They thus constitute the most complete and timely list available anywhere, due to the magazine's comprehensive circulation (more than 128,000 monthly).

NOTE: Readers are cordially invited to submit names of towns in which vacancies for doctors have occurred. Address them to MEDICAL ECONOMICS, Rutherford, N.J.

Switch halts waste of light current

After hurrying out of my office at night, I often used to wonder if all the electrical equipment had been turned off. Dim bulbs, like those in x-ray developing rooms, are easily overlooked. Once I returned to the office at midnight because I thought I might have left the sterilizer on.

I've since ended this source of annoyance and waste as follows:

I had an electrician run a cable from the fuse box to a switch inside my office door. Now, when I leave, I simply snap the switch and it disconnects the fuses, automatically breaking the circuit.—J. L. Kubrick, M.D., New York, N.Y.

So the doctor moved to Russia...

Was there anything left for him but vodka on the Volga?

Hardly, you'll agree, if you've read how Dr. Roberts tried to apply justice and common-sense in a socialized medical world—and found they wouldn't work.

Dr. Roberts' story appeared in April MEDICAL ECONOMICS, under the title, "Mothers in Uniform." Scores of physicians found its satire on state medicine so laugh-provoking that they requested reprints for their patients.

Such reprints are now available at cost: 60 cents a hundred. Address: Medical Economics, Inc., Rutherford, N.J.

NEWS

SEPT. 1939

Maryland Buries Coroner

Maryland's new Post Mortem Examiners Commission drives another nail in the coffin of the coroner system. Composed of Johns Hopkins and University of Maryland pathologists, the commission is selecting physician-examiners to take over the medical duties of coroners in the State.

Under a recent act signed by the Governor, the appointees must be licensed physicians, with training in pathology. The new positions will include a chief medical examiner for Baltimore, who will receive $6,500 annually; two assistants, at $5,000 a year each; and one or more deputies for each county. To be chosen from lists supplied by county medical societies, the latter will be paid on a fee basis.

Maryland's new system follows a path outlined by MEDICAL ECONOMICS in its March 1938 issue.

Co-ops to Rival A.M.A.

Acting on a resolution passed at the recent annual convention of Group Health Plans (cooperative-controlled medical prepayment schemes), a committee is organizing what it hopes will be a rival to the A.M.A. As Winslow Carlton, the committee's chairman, explains it:

"One of the [organization's] important purposes will be to duplicate in group medicine the work done by the American Medical Association."

Regarded as the most significant development arising out of the New York City conference, this move stole the show from a series of attacks on private practice led by:

Dr. Kingsley Roberts, director of the Association of Medical Cooperatives, who declared that such organizations have taken over more than 1,000,000 patients. He added that if the C.I.O. and A.F. of L. would adopt cooperative medical care, the resulting pressure would crush organized medicine's "opposition."

Dr. John P. Peters, of the Yale Medical School, who charged that, "under the present system, they [doctors] cannot hope to achieve anything important."

Dr. Hugh Cabot, who asserted that doctors know practically nothing, outside of medicine. He predicted that absorption of young men by co-ops would shelve older physicians, except for "their proper province as consultants."

Mercy Flights Doomed?

Abandonment of airplane flights to transfer patients from ships at sea to land is being considered by the Coast Guard. Spurred by the recent crash of a flying ambulance, with a loss of three lives, a committee is investigating the value of the service.

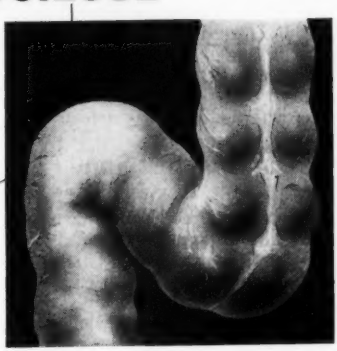
It heard Lieutenant John Hawes of the Naval Reserve medical corps testify that the Coast Guard would "do well to abandon such flights." Hawes gave as his reason: Lack of diagnostic facilities aboard ships; the hazard of the air trip to both patients and the planes' crews.

Another witness, Lieutenant Watson Burton, told the committee that such flights had cost the Government nearly $1,000,000 in wrecked planes, as well as many lost lives.

Bans Birth-Control Ban

Freedom of physicians to prescribe contraceptives is upheld in a decision by Connecticut's Superior Court Judge Kenneth Wynne. Freeing two doctors who had been arested on charges of

PREVENT TRAPPING IN THE COLONIC "*CATCH BASIN*" WITH MUCILOSE



WHEREVER POSSIBLE, the treatment of constipation should strive toward the production of a good drainage (normal) stool, thus avoiding the need for violent cathartic flushing.

MUCILOSE

helps to bring about a more normal type of peristalsis by providing bland, non-irritating, non-digestible, *lubricating bulk* in the colon.

We invite you to try Mucilose in constipation, colitis, and as a bulk-giving agent to supplement restricted dietaries.

Mucilose is a hemicellulose (vegetable gum) prepared by a special process from the Plantago loeflingii. You can prescribe it in either of the two palatable forms — MUCILOSE GRANULES or MUCILOSE FLAKES.

FREDERICK STEARNS & COMPANY
DETROIT, MICHIGAN
NEW YORK KANSAS CITY SAN FRANCISCO
WINDSOR, ONTARIO SYDNEY, AUSTRALIA

FREDERICK STEARNS & COMPANY
Detroit, Michigan Dept. M.E. 9
Please send me a supply of Mucilose for clinical test.
Name ..... M.D.
Address .....
City ..... State .....

giving birth-control advice to clinic patients, Judge Wynne called the State ban on contraceptives "unconstitutional" because it failed to exempt physicians from its provisions. Said he:

"The statute would offer no defense to a doctor facing prosecution for violation of it. Is a doctor to be prosecuted for doing something in the best traditions of a high calling? Should he be forced to practice furtively rather than give up what professional judgment dictates? The court is convinced that without these proper exceptions the statute is defective."

F.D.R. Against State Care

President Roosevelt does not think it proper to extend Government medical care to large groups of civilians. He said so himself recently in vetoing a bill that would have provided such service to employees of the U.S. Foreign Service and their dependents. Protesting that the cost—estimated at $21,000 yearly for about 6,500 patients—was "absurd," the President said: "This bill opens a new field of Government medical care. I do not believe Congress wishes to start the practice of extending such assistance to a large class of civilian employees."

Politics Snares M.D.

When Dr. Clarence A. Lorio, president—until recently—of the Louisiana State Medical Society, obtained a political job as physician to three State institutions, some colleagues thought him lucky. He received, it was said, over $10,000 a year.

But recent disclosures by the grand jury investigating Louisiana State University have brought a changed viewpoint. As a result of his association with George Caldwell, local political boss, Dr. Lorio has found himself indicted with Caldwell on charges of embezzling building material. In addition, he is accused of receiving stolen property. As soon as the indictments were made public, it was announced that he had resigned the society presidency.

Farm Belt Buckles

Rural patients will not support the Federal medicine drive, it is indicated in a statement issued by the National Grange. Dealing what is regarded as a heavy blow to New Deal hopes of backing from the agricultural interests, the farmers' organization put itself on record as opposing vast Government spending and further socialization. Stressing the need for more medical service in rural areas, the Grange deplored the swing toward specialism and called for more general practitioners. To effect this, it demanded that college pre-medical work be eliminated; that medical schools admit high-school graduates.

[*Turn the page*]

How a family doctor became so tired he turned inventor

THE doctor sat in his office with his head resting wearily on his arms. "Why in heaven's name, couldn't people remember what you told them?" Two more cases of gastro-intestinal infections and both after he had specifically warned the mothers to keep the nursing equipment clean.

Suddenly he opened his desk and looked at a nursing bottle. Maybe it was the equipment itself. Why couldn't a bottle be built with a wide mouth, with smooth-rounded corners, no cracks or crevices to catch dirt? Then anyone could keep it clean. Thus was invented and patented Hygeia Nursing Bottles and Nipples, 44 years ago.

Dr. Decker, who invented Hygeia after practising 18 years, was a fanatic on the subject of proper medical care before and after childbirth. Today Hygeia advertising tells many millions of people each month to "see your doctor regularly". And each month literally thousands of doctors recommend easy-to-clean Hygeia Bottles and breast-shaped Hygeia Nipples. These Hygeia recommendations help us and we hope and believe that each Hygeia advertisement helps doctors. Hygeia Nursing Bottle Co., Inc., 197 Van Rensselaer St., Buffalo, N. Y.

Special offer to hospitals. Hospitals may now buy Hygeia Bottles and Nipples at approximately the same cost as ordinary equipment.

HYGEIA

the Safe

NURSING BOTTLE AND NIPPLE

Strike in New Zealand

Faced by a Government medicine program passed over their opposition, New Zealand physicians have called a nationwide strike. Main issue is not the new law itself, but whether it is to cover all patients or only the indigent. It taxes all income one shilling per pound sterling in return for a number of benefits, including medical, maternal, and hospital care. The Government plans to introduce these benefits one at a time. To open the program, it sent contracts for maternity cases to physicians. Only twenty-two signed. In retaliation, the Government forces threaten to fill the jobs with refugees.

Malpractice Law Tricky

The value of protection against malpractice suits was brought home recently to Drs. Harold D. Barnard, Charles L. Lowman, and Edward N. Reed in a way they won't forget. It seems that seventeen years ago, one Adin Alexander was treated by them for a fractured arm. Thirteen years later the physicians received a rude shock: Alexander claimed that the arm hadn't been properly set; demanded damages of $100,000. Although the first hearing of the moth-eaten claim in a Los Angeles court resulted in a mistrial, and the second in a hung jury, the doctors were glad to settle out of court. Cost: unpleasant publicity—and $8,000.

Another "Health" Bill

A bill that would vest control of large funds for tuberculosis care in the Federal Government has been introduced in the Senate. Sponsored by Senator James E. Murray (D.), of Montana, it proposes spending up to $37,000,000 yearly in Federal monies on this disease.

Administration would be nominally by the States, though the Surgeon

General of the Public Health Service would decide the allocation of appropriations. The measure endows him with other broad powers, among them: that State programs must meet his approval; that he can "prescribe rules necessary to carry out . . . this Act"; that he is in charge of a new branch of the service to be known as the "division of tuberculosis control." Among the latter's employees would be, according to the bill, "such professional . . . personnel as may be necessary"—presumably doctors.

Call N.H.P. "Red"

Catholicism's war on compulsory health insurance was continued with a new barrage at the Catholic Hospital Association's recent convention in Milwaukee, Wis. Denouncing the panacea as the beginning of "atheistic communism," John A. McNamara, Cleveland Hospital Service director, warned priests, nuns, physicians, and laymen attending:

"As soon as you have a Government program, religious organizations which run hospitals are through. When you go out, religious influence will go out. The Government will replace you with ward heelers. That is what the leftist groups want."

To which, Kansas City's Bishop Edwin V. O'Hara added:

"Nowhere is charity forwarded as in the United States. The forces of secularism seek to use the very agencies destined for the protection of rights, for destruction of liberties which find their protection in Christian philosophy. They would dethrone the Sacred Heart of Jesus."

Odyssey of Lina

American physicians may soon have a chance to observe Lina Medina, Peru's alleged five-year-old mother. Arrangements to bring the child and her offspring, Gerardo Alejandro, to hospitals and universities in the United States for study are being completed by Dr. Abel Larrain, of Chicago. The tour will be solely for "scientific, cultural, and educational purposes," it is said, with "absolutely no exhibitions." There is a possibility, it is added, that a university will build a home for Lina and her baby; install them as objects for research.

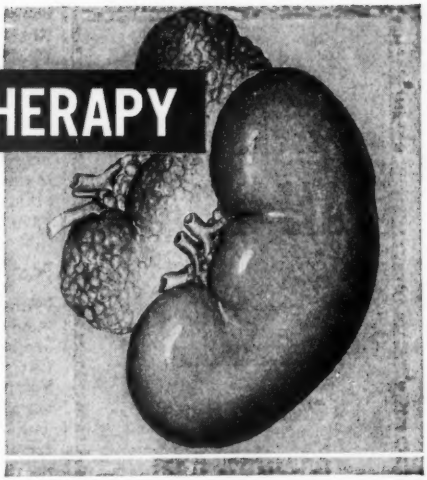
State Medicine Bible?

Adoption of Dr. Morris Fishbein's "Modern Home Medical Advisor" as a text book is urged upon the Government medicine forces by the Philadelphia County Medical Society's Weekly Roster & Medical Digest. Putting forth this suggestion, the magazine comments:

"The family doctor book, devised for the benefit of the intelligent lay public and Dr. Fishbein, seems to belong to the armamentarium of the

ORGANOTHERAPY

has brought new hope to nephritic patients



It was Brown-Séquard and d'Arsonval, who in 1892 discovered that the administration of kidney extract could postpone uremic manifestations and markedly prolong life—through an internal secretion of the kidney that vitally activates the glandular tissues.

Nephritin provides a preparation carrying unchanged the active principles of the kidney, free from preservatives and toxic elements. It is neither a glycerin nor aqueous extract.

Clinical evidence attests its value in the various types of renal disease amenable to therapeutic assistance. It augments urinary flow, relieves nocturnal polyuria, increases the quantity of urea and total solids, decreases the number of blood cells and casts, and reduces edema. Administration must be started early, with adequate dosage, from 16 tablets daily upward, and continued with such doses as the case requires. Send for samples.

HOW SUPPLIED

Bottles of 80, 500, and 1,000 tablets.

DOSAGE

Four to six tablets, four to eight times daily—according to the severity of the condition.

REED & CARNRICK · JERSEY CITY, N. J.

NEPHRITIN

MADE BY THE PIONEERS IN ENDOCRINE THERAPY

committee headed by Miss Josephine Roche. By the judicious use of it, the Public Health Service could carry on without spending 850 millions yearly, and if the advertising agency handling the publication doesn't weaken, the entire population of the country may find itself without need for additional medical advice. Unquestionably, the potentialities of this work have been underestimated."

No More Tickets

Protests of physicians against summonses for illegal parking have brought welcome relief. New York City's Police Commissioner Lewis J. Valentine agreed last month that parking regulations should not interfere with the saving of life. He has ordered police officers to exempt cars bearing medical-society emblems from ordinary restrictions. In addition, he is issuing cards to medical-society members, which grant immunity against parking laws during visits to patients.

Health to Walk Planks?

Both major parties will include socialized medicine planks in their 1940 platforms, it is predicted in a statement issued by Dr. R. G. Leland at Memphis, Tenn.

Perhaps inspiring the A.M.A. leader's prophecy was the declaration of policy a few days previously by Senator Robert Taft, of Ohio, a leading Republican Presidential possibility. Speaking at the laying of the cornerstone for Washington, D.C.'s new Doctors Hospital, the Senator expounded his attitude in a cautious, amply-worded address. Demanding amendment of the Wagner Bill, with the "assistance and cooperation" of the medical profession, to eliminate "State-controlled care," he said:

"A Federal-aid program can be worked out. It can be simpler, more economical, and more likely to pre-

serve the independence of the doctors. No great proportion of doctors [should] ever become employees of the Government. I see no reason why present individual service should not be preserved, even if we adopt Federal financial assistance."

Must Pay to Compete

If they wish to conduct private practices in California, U.S. Army, Navy, and Public Health Service doctors must pay the State's annual registration fee. So Attorney General Earl Warren has notified Dr. Charles B. Pinkham, secretary-treasurer of the California Board of Medical Examiners. Complaints against this competition from Government physicians, who supplement their incomes by engaging in private practice, have been heard lately in several States.

Proves Own Diagnosis

Dr. E. H. MacPherson is a physician with the courage of his diagnosis. When Millburn (N.J.) colleagues reported not long ago that three patients had ptomaine poisoning from eating chocolate eclairs, Dr. MacPherson dissented. He believed their symptoms were due to playing golf under a hot sun, then eating a heavy meal accompanied by cold drinks. To prove his contention, he gulped down two of the supposedly poisonous pastries; waited three weeks for something to happen. Nothing did. Concluded Dr. MacPherson: "The eclairs are exonerated."

Wake Before Sleep

By the time this appears in print, Claude J. Bradley may be dead. At best, the end is not far off for this 53-year-old victim of inoperable spinal carcinoma. To celebrate his passing, Bradley recently threw a party for 200 in New York City. It was a gay affair. The host appeared the happiest man there. He cheered his sad friends by cracking jokes and playing rollicking tunes on the piano. "When you gotta go," he explained, "you gotta go!"

Rehearse Socialization

At the taxpayers' expense, the California Relief Administration is conducting what it admits are experiments in Government medicine. According to State Relief Administrator H. Dewey Anderson, $10,000 has been appropriated for treating 100 selected relief patients; $975 for ambulance service; and $6,250 for dental care. In addition, an unknown sum is expected to be devoted to the construction and maintenance of hospitals.

That this may be just the beginning is indicated by the relief director's admission that no one could calculate the final cost of the experi-

Iron ---

FOR THE INFANT

Protection againt secondary anemia is essential for the infant during the first year of life. While a limited supply of iron is stored during the pre-natal period, this reserve is frequently dissipated during the lactation period.

The infant's reserve supply of iron may be supplemented by Neobovinine with Malt and Iron, an excellent source of liver, iron and mineral salts essential to the regeneration of hemoglobin in the red blood cell.

Neobovinine with Malt and Iron is a thin, palatable liquid preparation easily combined with milk or fruit juices for infant feeding.

Available on prescription, at all pharmacies, in eight ounce dispensing bottles.

THE BOVININE COMPANY
8134 McCormick Blvd., Chicago, Ill.

ments. On the basis of the results, he explained, an appeal will be made to the State legislature for more funds. Said he: "I've been an ardent believer in socialized medicine for a long time. We're now bringing it to California."

Good Will Tour

Last May, Drs. Roscoe C. Giles, Carl G. Roberts, and Clarence H. Payne—all colored—hopefully embarked for the A.M.A. convention in St. Louis. They called themselves the Good Will Committee. They had four demands to present to the A.M.A. on behalf of their Negro colleagues.

First, they asked deletion of the "col." after their listings in the American Medical Directory.

Second, recognition in the A.M.A.

Third, participation in Government projects.

Fourth, inclusion in organized medicine's scientific benefits.

The trio's own version (condensed) of its *Wanderjahr* follows:

"Early Monday morning, the committee asked for Dr. Olin West. They were told that Dr. West was busy; that they would be advised of the time and place of the meeting to consider their demands. Meanwhile, Dr. West passed by the open door of the committee members' room. . .

"The committee waited until eleven o'clock Tuesday morning. Then, having received no call, they again inquired. They learned that the reference committee had already considered the propositions in which they were interested. The House of Delegates had voted down the admission of Negro physicians. The 'col.' behind their names had been referred back to the trustees.

"The committee later received a message to report to Suite 106, Statler Hotel, at 6 P.M. They found only a darkened room. . .

"They finally did get before a committee on Wednesday. This, however, was not the original reference com-

mittee of twenty-five members, but a committee of five."

Diplomatically, the weary travelers conclude:

"We do not infer that our committee was purposely sidetracked. But this circumstance is, to say the least, very unfortunate."

Birth Still "Indecent"

Only when "clinical purposes" are being served may New Yorkers view that controversial film, "The Birth of a Baby." So has ruled the Appellate Division of the Supreme Court in that State. Otherwise, the judges added, the ban imposed on its showing by the State Board of Regents will have to stand. Weighing the question of the production's "indecency," the court said:

"This picture is not inherently indecent in the ordinary, accepted sense. But it becomes indecent when presented in places of amusement. Exhibition of this picture for entertaining adults and children would serve no useful purpose."

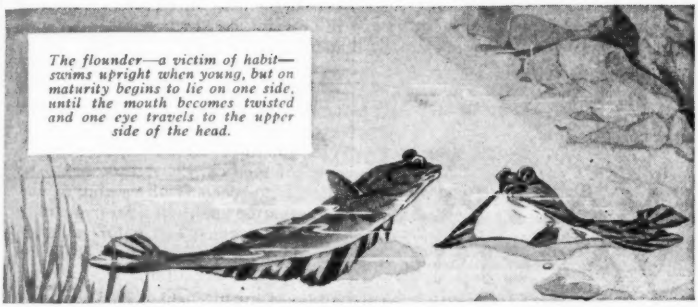
Hail Heap Big Wigwam

When Fort Defiance, Arizona, recently opened its new 250-bed hospital, it was felt only tactful to ask native Indian medicine men to dedicate it. But the local profession was hardly prepared for what followed. Swooping down on the building, some 350 chanting Navajo witch doctors took possession of it. They spread Buffalo robes in the modern corridors, then scattered meal on them. After which they took the elevator to the next floor, where they repeated the ceremony. Only difficulty the red men encountered was what to call the institution, since the Navajo language has no word for a house with more than one room. They got around this by inventing a term especially for the occasion.

FSA Plan Reborn

Not long ago, Federal officials regretfully read the obituary of Government-controlled medicine among North Dakota's Farm Security Administration clients. Eight months of operation, newspapers said, had proved it a costly failure. On the heels of this announcement, however, came another, resurrecting the corpse and granting it at least two or three more years of life. Already in effect, the new program raises the annual cost of medical care to each family from $24 to $33.

Further extensions of FSA activity in the medical field are now being organized in Texas and Oklahoma. Alarmed by the possible consequences of such a movement in Idaho, the State medical association's house of delegates recently participated in a meeting to consider the problem. As a result, it urged its component so-



The flounder—a victim of habit—swims upright when young, but on maturity begins to lie on one side, until the mouth becomes twisted and one eye travels to the upper side of the head.

Victims of Habit

More often than not, constipation is the result of habit rather than anatomical defect. The nearest approach to elimination of the cause is an attempt to restore physiologic activity of the colon by establishing a daily routine.

To assist you in the difficult task of training the patient with constipation, you have at your disposal the three types of Kondremul, which allow a gradation of treatment for all types of constipation:

In resistant cases, Kondremul with Phenolphthalein (2.2 gr. per tablespoonful) will provide symptomatic relief. As the condition improves, Kondremul Plain may be substituted.

In ordinary atonic constipation, Kondremul with non-bitter Extract of Cascara may be administered at first, using Kondremul Plain later.

For mild cases, and in the constipation of pregnancy and childhood, Kondremul Plain will, by softening the fecal mass, enable the patient to eliminate easily and naturally.

KONDREMUL

a palatable emulsion containing 55% mineral oil, in which Irish Moss (chondrus crispus) is used as an emulsifying agent.

THE E. L. PATCH COMPANY
Boston, Mass.

THE E. L. PATCH COMPANY, Dept. ME-9
Stoneham P. O., Boston, Mass.

Gentlemen: Please send me clinical trial bottle of

- ☐ KONDREMUL (with Phenolphthalein)
- ☐ KONDREMUL (with non-bitter Extract of Cascara)
- ☐ KONDREMUL (Plain)

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cieties to insist upon these standards in entering contracts with the Government:

That control of funds be by a board, on which the profession has at least equal representation with any other group; that all bills be under the jurisdiction of an "auditing committee" of medical men; that not more than $1 of each family's annual contribution be spent on administration; that free choice of doctor be guaranteed patients; that fees be in accord with those of the State industrial accident board and the fee-schedule of the Idaho Falls Medical Society.

Obstetrician's New Duty

Doctors would be required to provide names for the illegitimate children they deliver, under a Constitutional amendment sought by Dr. Mary Halton, of New York City. The suggested national law would make illegal all birth certificates distinguishing between the children of married and unmarried parents. "Every birth certificate would have a father's name on it—even if the doctor had to invent it," Dr. Halton declares. "At the risk of jail, I've been doing that for years."

Bar Calls by Radio

For five years, Sherman Amsden, director of a New York City service that answers absent physicians' telephone calls, has dreamed of paging doctors by radio. In 1934, he applied to the Federal Communications Commission for a permit to build a broadcasting station for this purpose. His application was vetoed because the desired frequency was reserved for experiment. When a re-allocation threw the frequency open, Amsden applied again.

Now the commission has turned him down a second time, on the ground that he has not proved the station a "public necessity." Undaunted, Ams-

den told MEDICAL ECONOMICS that he is planning a third appeal.

He will not seek aid in the courts, he declared, because "we haven't received any support from the medical profession." He charged that "some narrow-minded punks" in the A.M.A. had brought pressure on the commission to kill his proposal.

Anti-Alien Laws Pass

In response to appeals from American physicians for protection against foreign competition, four more States have acted to restrain the influx of refugee physicians.

Most sweeping is the series of measures just passed by the Illinois legislature and signed by Governor Henry Horner. The brainchild of Senator Earl B. Searcy (R.), of Springfield, it bans issuance of licenses to practice medicine, pharmacy, and chiropody to all foreigners.

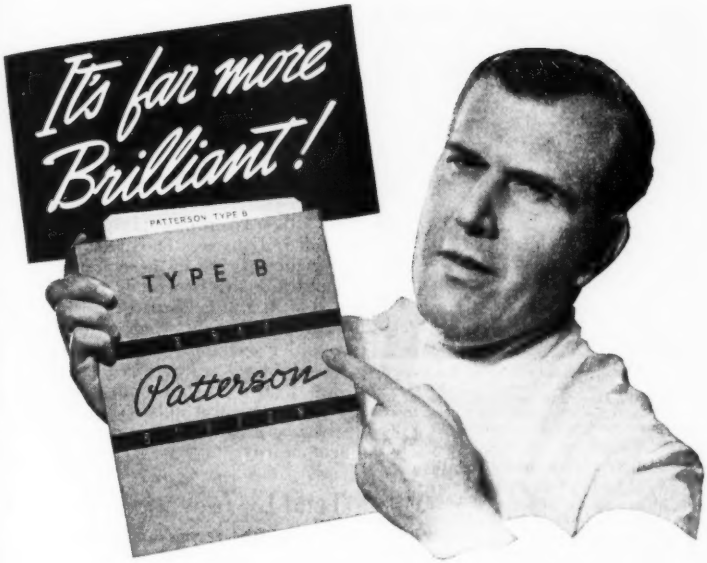
New Hampshire has also climbed aboard the bandwagon. Its new law admits only American citizens to its licensing examinations. Single loophole is a provision excepting Canadian residents of a province that grants New Hampshire doctors reciprocal privileges.

Similar, but less stringent, is a bill sent to Massachusetts' Governor Leverett Saltonstall, after having been approved by the legislature. It requires first citizenship papers of candidates for licensing examinations; grants aliens already in practice one year to apply for citizenship. Specialists from abroad, in the State on a short visit, are excepted.

In Utah, seven applications a week from refugees seeking medical licenses are spurring the movement to protect local practitioners. There the attorney general is considering whether *full* citizenship may be made a condition to practice in Utah. The proposition was submitted by G. V. Billings, director of the State department of registration. Billings cited the following resolution, passed recently by the State Board of Medical Examiners:

"All applicants for license to practice the healing art must present evidence of full citizenship. All citizens who are graduates of foreign schools, except [those of] Canada, must pass examination before the National Board of Medical Examiners before applying in Utah."

Meanwhile, a report of the New Jersey Board of Medical Examiners provides some interesting statistics. It reports that the rate of failure in the State's 1938 licensing examinations was only six-tenths of one per cent among American graduates, as compared with over 37 per cent for foreigners. Of native-trained candidates, 162 of 163 passed; of those from Canada, Great Britain, France, Germany, Italy, Switzerland, Austria,



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Type B THE WORLD'S FINEST **FLUOROSCOPIC SCREEN**

Czechoslovakia, and Hungary, 44 of 117 failed.

Not even far-off Australia is without its refugee-doctor problem. All Australian states are now closed to alien M.D.'s, no matter how exceptional their qualifications. To the argument, also heard in that country, that refugees should be permitted to practice in rural sections lacking doctors, the Australian profession has replied: If natives find it impossible to make a living in those areas, how could foreigners succeed?

B.M.A. attitude is that British physicians come first; that if any communities need doctors, natives should be subsidized to locate in them. Only if a British M.D. cannot be found for a practice, it holds, should it be given to a foreigner—and then only temporarily.

Trial by Jury

A favorable reception to voluntary health insurance plans seems assured—if Cincinnati women are representative. To determine popular reaction to prepaid medical care in that city, the idea was submitted recently to a "jury" of 1,000 women from all stations in life. Nearly 77 per cent said they would join an association that would furnish physicians' services and hospitalization for a fixed annual fee. Almost 98 per cent of them insisted upon free choice of doctor.

Bernarr Blossoms Out

To his followers, Bernarr Macfadden seems the personification of the "dynamic health" he promises them. But under the leopard skin, it now appears, the physical culturist has been harboring a secret. Disclosing it in a promotional leaflet issued recently, Macfadden states that he was "threatened" with tuberculosis "as a boy" but "cured himself through physical culture." Nevertheless, the leaflet adds, "all these years he has had to

Comparative Effects of Alka-Seltzer and Aspirin on Urinary Acidity

CROSS-SECTION TABULATION OF EXPERIMENTAL RESULTS

SUBJECT	TIME IN HOURS	ALKA-SELTZER pH	ASPIRIN pH
T. C.	control	6.24	6.62
		FOUR TABLETS GIVEN	
	1	6.99	6.41
	2	7.94	6.45
	3	7.86	6.82
	4	7.76	7.09
W. C.	control	5.00	6.28
		FOUR TABLETS GIVEN	
	1	7.21	7.00
	2	7.81	6.84
	3	7.87	6.83
	4	7.69	7.15
J. M.	control	6.37	5.62
		TWO TABLETS GIVEN	
	1	7.84	6.95
	2	8.22	7.72
		TWO TABLETS GIVEN	
	3	8.04	6.91
	4	8.03	6.64

ANOTHER phase of a lengthy series of investigations of Alka-Seltzer is illustrated in the accompanying tabulation.

This, and other controlled experiments, were undertaken in order to determine and define the limits of Alka-Seltzer as a means of affording relief in certain minor ailments.

A digest of the complete findings of the investigators will shortly be published and will be sent with our compliments to interested physicians.

CONCLUSIONS

Following the administration of Alka-Seltzer marked increases in urinary pH were found.

A pH of over 7.0 and in some cases over 8.0 was obtained by the end of the second hour in all cases and continued at that level through the experimental periods.

After aspirin only slight changes were found; increases in pH to 7.0 were observed only in three subjects but the increase was not maintained for more than one hour.

fight . . . this terrible complaint." As the result of "handling his own case . . . not counting thousands . . . with whom he has come in contact through his writings," he is claimed to have acquired "invaluable knowledge."

This knowledge is now being dispensed at the new Loomis Sanatorium, Liberty, N.Y., of which Macfadden is chairman. Described as a nonprofit institution, it will treat the tuberculous with "Bernarr Macfadden's successful dynamic health building system."

Hits Specialty Listings

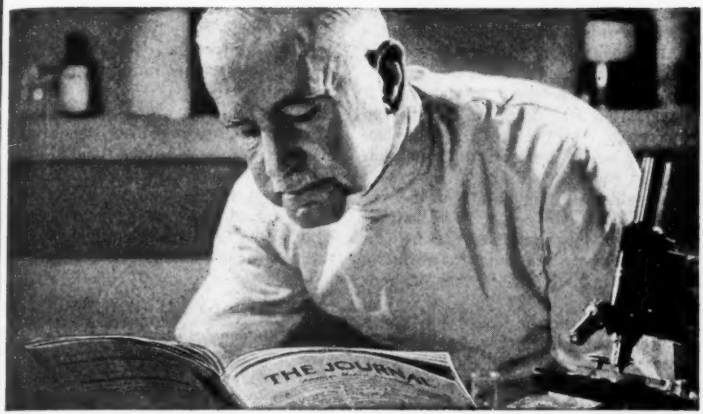
Latest medical society to disapprove the designation of specialties in classified telephone directories is that of Passaic County, N.J. In its ruling, the society's welfare council declared that such listings are covered by the section of the Principles of Medical Ethics reading: "It is unprofessional . . . to employ any methods to gain the attention of the public for the purpose of obtaining patients." Listing of office hours, however, was approved.

Wagner Bill's Rival

A rival to the Wagner Health Bill was introduced in the Senate last month by Senator Henry Cabot Lodge, Jr. (R.), of Massachusetts. Purpose of the measure is to amend the Social Security Act to cover the medical bills of the unemployed. As its sponsor sees it, they could be paid out of the present old-age-reserve fund without further taxation.

Benefits under the measure would be limited to $25 per person annually; $100 in all. To be eligible, patients would have to have been unemployed for at least fifteen consecutive weeks; to have earned taxable wages of at least $5,000 after Dec. 31, 1936. Recipients of old-age benefits would be specifically excluded.

Control of payments would be in



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when you read our advertising

We sincerely mean this request. We would like you to read Gerber advertisements and literature in a critical, fault-finding mood. If they contain any statement which impresses you as misleading or exaggerated, we will immediately change it.

This is a strong assertion. But we make it confidently because no claim is made about Gerber's Baby Foods without first consulting doctors, dietitians and nutritionists; and because every advertisement is submitted to the Council on Foods of the American Medical Association before it is published.

We have tried hard to deserve your confidence and the confidence of mothers. We feel that by asking your help we are taking another and important step in preparing advertising which is honest and sincere.

Gerber's
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Please send me samples of current literature and advertisements on Gerber's Baby Foods.

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the hands of the Secretary of the Treasury and the chairman of the Social Security Board. Patients seeking aid would apply to the board, enclosing a bill for medical services and a physician's affidavit that the charge was reasonable. Any licensed practitioner would be eligible to participate in the program.

To guard against abuses, fines of up to $1,000 and a year in jail would be provided for false statements. In addition, physician-violators would be reported to their State licensing bodies.

Declaring that he would not "press for action at this time," Senator Lodge nevertheless attributed the following benefits to his brainchild:

"The total cost in 1940 will be less than $1,000,000. The needy will receive immediate relief. The taxpayer will not be affected. Doctors and hospitals will receive compensation for furnishing care to those whose slender resources have not been able to stand the strain of essential medical assistance. The individual will choose his own doctor. Questions of medical personnel and standards will remain in the hands of physicians."

Society Gets Its Law

From now on, candidates for New Jersey chiropractic licenses will have to show at least six years' training, instead of the two to four years required formerly. This new law is the latest achievement of the New Jersey Medical Society's campaign to raise standards via legislation. To its active backing goes much of the credit for the bill's passage and acceptance by Governor A. Harry Moore. Despite severe opposition, the physicians' arguments induced the Governor to rebut chiropractors' contentions that the measure would drive them out of existence. His position: The bill will not affect any chiropractor now practicing.

'Frisco Furor Mounts

Plans to ease the financial troubles of San Francisco's compulsory health insurance project for municipal employees have ended in the resignation of two committeemen appointed to the job. Abandoning their attempt to cut the organization's administration costs, Charles T. Butterworth and Martin Wormuth explained that their efforts had been hamstrung.

Soon after their resignation, it was announced that the project's board had decided not to reduce Director Walter B. Coffey's salary from $1,000 to $750 monthly.

Among the charges filed by the resigning committeemen were:

That reorganization of the administration—described by Board Chairman Cameron King as an economy measure—really aimed to introduce political patronage and the "spoils system." Elevation of Francis Robin-

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3. Your patients welcome its pleasant, easily-taken, easily ingested, dosage forms—and therefore willingly adhere to your routine.

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5. White's Cod Liver Oil Concentrate is available in three economical, convenient dosage forms—Liquid, Tablets, Capsules—well suited to the needs of every type of patient.

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The widespread professional recognition of White's Cod Liver Oil Concentrate is obvious in the fact that White Laboratories are today one of the world's largest users of cod liver oil for pharmaceutical purposes. White Laboratories, Inc., Newark, N. J.

ACCEPTED AMERICAN MEDICAL ASSN

son, former clerk, to the post of "coordinator of administration and medical offices" was cited. Robinson is King's son-in-law.

That the cost of remodelling and furnishing the service's new quarters in San Francisco's municipal auditorium will be double the original estimate of $3,000.

That although the medical funds showed a surplus of $1,038, the board voted to pay the organization's panel physicians only 50 cents on the dollar. This was the fifth successive month that the doctors have suffered severe slashes in their fees.

Behind the Addict

Individuals who become accidentally addicted to drugs through their use in illness are a distinct minority, according to Passed Assistant Surgeon M. J. Pescor, of the U.S. Public Health Service. After studying 1,036 addicts at the service's hospital at Lexington, Ky., Dr. Pescor declares:

"Individuals addicted through intermediate use constitute only 3.8 per cent of the total. Even this figure is probably too high."

The "*average* addict," says Dr. Pescor, becomes a victim through curiosity and association with other drug users. Such addicts constitute 54.5 per cent of the group studied.

Dr. Pescor pictures the "average addict" as follows:

White, male, 38 years of age. Sentenced for illegal sale of narcotics. Parents in marginal economic circumstances. Native, of native parentage. Childhood apparently normal. Graduated from the eighth grade. Occupation: domestic.

Lived formerly in deteriorated metropolitan section. Resorted to illegal means to support his habit. Marriage terminated in separation or divorce. No children.

Addicted at 27. Used more than one narcotic, but preferred morphine.

No voluntary attempts at cure. Will not remain abstinent longer than two years.

First arrest at 28 for violation of drug laws. No delinquency record prior to addiction. Offenses after addiction confined to violation of drug laws. At least one penitentiary sentence and one jail sentence.

In the institution, abides by regulations, shows knowledge of his occupational assignment, and is a willing worker. Custodial officers find him pleasant and agreeable. As release approaches, will maintain he is through with drugs forever. Still thinks drugs beneficial, but says the penalty outweighs the benefit. Will plan to live with relatives. Will get no offer of employment. Will be given an average prognosis for permanent cure. Will relapse.

"Sub-Dentists" For Poor?

Creation of a special professional class to attend the low-income groups is urged by Dr. Russell W. Tench, New York State Dental Society president. To be known as "sub-dentists," the new group would enter dental school directly from high school. After only three years of professional study, they would enter practice; they would be allowed, however, to conduct only simple procedures. In making his proposal, Dr. Tench observed that the present long, expensive education is absurd, if graduates are to be forced to serve clinics at low salaries.

Collects After 50 Years

Nearly a half-century ago, Dr. W. N. Smiley of Rowdon, Quebec, leaped into the saddle and galloped twenty miles on horseback to answer an emergency call. He arrived in time to deliver a farmer's wife of a boy. When the father explained he couldn't pay, the physician replied that if he brought up his son properly, he would be compensated. Not until recently, when a

successful Providence, R.I. business man visited Dr. Smiley to pay a bill, did he realize how truly he had spoken. His caller was the "baby" he had delivered.

Data Sale Denounced

Since last January, New York City's private practitioners have been asked to file special, detailed reports on the causes of patients' deaths. To encourage cooperation, health officials sent out form letters assuring each doctor, in capital letters, that "THE DIAGNOSIS RECORDED IN THE CONFIDENTIAL REPORT WILL NOT BE DIVULGED."

Hence the furor created by the city's recent decision to sell these reports to the Metropolitan Life Insurance Co. for 50 cents each. This action was approved, 3 to 2, by the local board of health. Voting for the sale were Health Commissioner John L. Rice, Dr. Thomas M. Rivers, formerly of the Rockefeller Foundation; and David M. Heyman, a layman. Against it were Drs. Haven Emerson and John E. Jennings.

Professional protests appeared as soon as the news leaked out. Leaders of the city's five county medical societies denounced the bargain unanimously as a betrayal of the doctor-patient relationship.

Summarizing the viewpoint of medical men, The Medical Week, organ of the New York County Medical Society, editorialized: "Physicians' confidential reports ... are not intended to be a source of revenue to the health department or of information to corporations which might use them in litigation ... The department's failure to respect its pledge cannot fail to have deplorable results. Physicians will be reserved in their reports, not knowing to what use the latter might be put."

Talks with medical men revealed the fear that such information might be used by an insurance company against beneficiaries. Although the patient's name does not appear on the forms furnished to the company, the month of payment, kind of insurance, and some description of the patient do. Given these facts, it was said, policyholders can easily be identified.

A few doctors went so far as to predict that the result will be to discourage patients from consulting physicians. Applicants for insurance, they pointed out, are usually asked if they have been to a doctor within two to five years before application. If evidence of visits during that period is made available to insurance companies—with the possibility that the companies may use the evidence later to deny policy benefits—the doctors asked, what is to stop many policy applicants from avoiding the risk by *foregoing* medical attention except in dire emergencies?

Court action was taken by the Metropolitan, back in 1928, to obtain simi-

Fair and fragrant are the blossoms from which Hawaiian lei makers fashion Hawaii's graceful tribute to visitors.

You'll think of flowers and tropic sunshine when you drink fragrant, golden Dole Pineapple Juice from Hawaii. An exciting flavor—a refreshing tang—make Dole a drink to perk up the most lackadaisical appetite.

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DOLE PINEAPPLE JUICE FROM HAWAII

Moisture	84.3%
Total solids	15.7%
Total ash	0.4%
Fat (ether extract)	0.1%
Protein (N x 6.25)	0.3%
Crude fiber	0.08%
Total sugars (invert)	12.7%
Total acid (as anhydrous citric)	0.8%
Carbohydrates (by difference)	14.8%
Brix (by refractometer)	14.7%
pH	3.53%
Calories/gram	0.6
Calories/ounce	18

Pamphlets on SOCIALIZED MEDICINE

For Distribution to Your Patients

Do you believe the public should be taught the evils of socialized medicine? Then you'll want to do your part by distributing copies of the pamphlet shown above. They're available *at cost*: 25c per carton of fifty.

Simply place a carton on your reception-room table. Fold back the top, which reveals the words, "Take One!" And patients will help themselves.

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Medical societies may obtain the pamphlets in large lots (without cartons) for distribution among service clubs, legislative bodies, and other opinion-molding groups. Address: MEDICAL ECONOMICS, INC., Rutherford, N. J.

lar information. It was frankly stated then that the facts were desired for use in litigation. The plan was denied on the ground that such disclosures would damage the confidence of the patient in his doctor.

Admitting the possibility of the Metropolitan's employing the diagnosis in connection with claims, Health Commissioner Rice nevertheless said he was certain this would not be done; that the information was for scientific purposes only.

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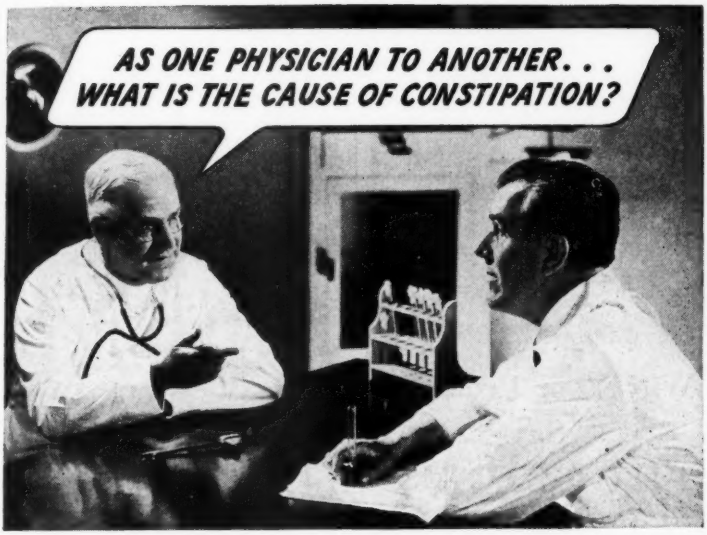

OBVIOUSLY, there is no single cause. Each case must be judged on its own merits. Anatomical differences, variations in diet and habit and specific pathological entities all enter into the cause. However, it is safe to say that faulty habit plays a role in the great majority of cases, and that loss of neuro-muscular tone is a very common secondary factor.

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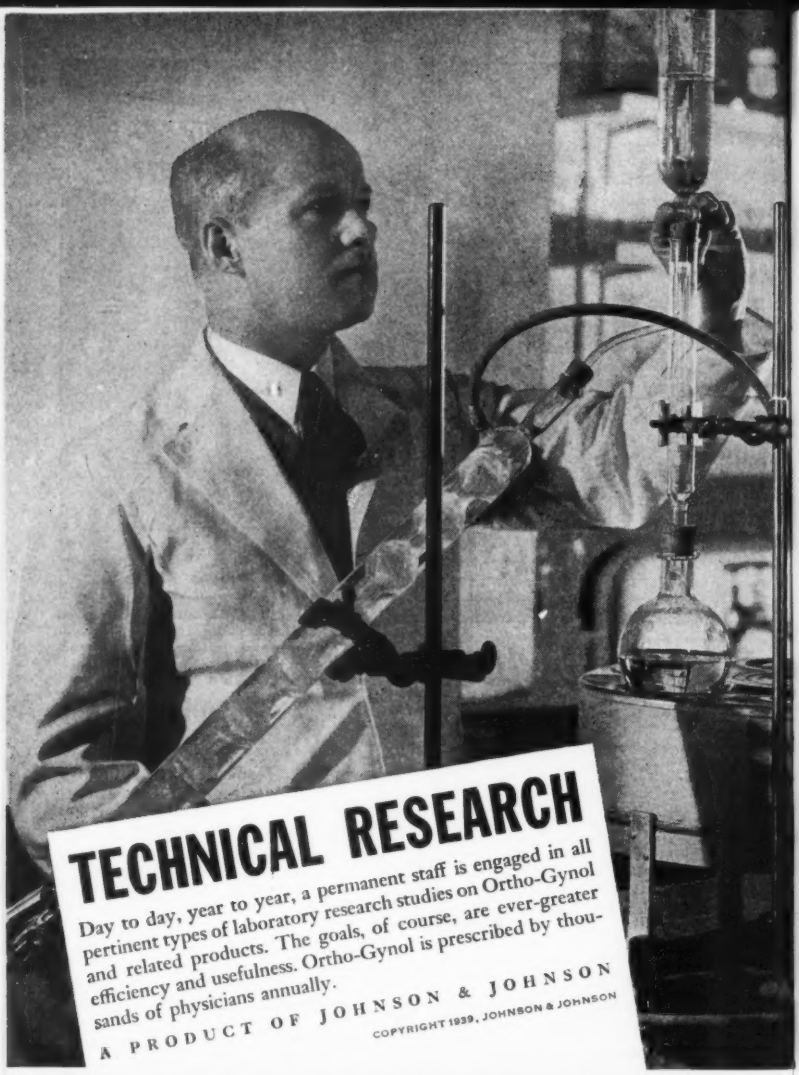

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